Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Catherine 2012 Barbara Davies 12:15 P.<sup>™</sup> August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brightview Assisted Living Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min. (Month, Day, Year) Director 384-07-6993 1 🗆 M 2 🔀 F 93 Oct. 6, 1918 Ohio 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 Yes 2 XNo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Linwood Ct. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 交 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give altimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Russell Howard Gribler Elsie (nmn) Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> William H. Francisco / Son-In-Naw</u> 4 Linwood Ct., Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hamilton Cemetery 9-1-2012 Decatur, MI 21. Signature a Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysiciani disease or condition resulting in death) ens stagenementi Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burnal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) Month Day Year 1 Yes 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sate has been significated be page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifie

31. Date filed (Month, Day, Year) AUG 1 0 2012

AUG 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-5 W. MQ

32. Registrer's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D32256

29d. Date signed (Month, Day, Year)

T

1012

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		State Registrar		Certificate of Death Reg. No.									
Physicia Medic		1. Decedent's Name (First, I	Middle, Last)  JOSHUA	FE	LDMAI	<b>V</b>	2. Date of De Month	Day	Year OIZ	3. Time of Death			
Examir		THEJOHNS	itution, give street and number) 5 HDPKINS HOS	SPITAL	4b. City, Town,	MOR	E (	CITY	4c. Count	y of Death			
Funeral Director		5. Social Security Number 216-47-4793 Usual Residence of Deced	1 <b>X</b> M 2 □ F	n yrs. last birthday)  16 Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da		9. Birthp Count	olace (State or Foreign try)  MD		
Maryland 28a-f show otified at	irector	10a. State 10b. C		Dc. City, Town or Loc				,	, = , , ,	11	0d. Inside City Limits 1 ☐ Yes 2 🏹 No		
fter o	Funeral Director	10e. Street and Number 3169 WILLO	W LANE		10f. Zip Code 44122		_		10g. Citizen of USA	What Coun	try?		
	by	11. Marital Status  1 🕅 Never Married 2 🗆 3 🗆 Widowed 4 🗆 Div	If Van Cive	1	Was Decedent of f Yes, specify Cut	an, Mexican	, Puerto	ecify Yes or No- Rican, etc.)	7 11 1100	ce - America ack, White, e	etc.		
within 72 ho giene. er than "nat the Medica	Completed		ecedent's Education v highest grade completed) 0-12) College (1-4 or 5+)	(Give I	dent's Usual Occu kind of work done O NOT use retired STU	during most	t of worki	ing		Kind of Business/Industry  EDUCATION			
ld be filed Mental Hyg arked oth	To Be	17. Father's Name (First, Mic	ddle, Last)	FELDMA				e (First, Middle,	Maiden Surnan				
and 2 shoul fealth and I sm 27 is ma her traums		19a. Informant's Name/Rela	N / FATHER	316	ng Address (Stree  9 WILLOW						ode)		
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permit. Departn Importa any inju	1 0	21. Signature of Funeral Se	use, or complications that caused the			ISTERS	STOW	N ROAD,	PIKESV	ILLE,	MD 21208		
Ph <sub>_</sub> sician/ Medical		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	. List only one cause on each line.	Barr viru				·			Approximate Interval Between Onset and Death		
Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Di Georg	e Syndr	me								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):									
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To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the		4 Homicide d	building, etc. (S)										
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KM		▶ Shi	erson who completed cause of death	(Itam 22a) /Firm D			)		29d. Date signe	-/ 2	012 D 21287		
Stat	te	31. Date filed (Month, Day, Y	1MY HONG  (ear) 32. Registrar's S	1800 Signature	ORLEA	ins s	TRE	ET BI	ALTIMOR	EM	D 21287		
Registra	ar	MUG I U 201	Laura . A.	backer									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Tate House Linthicum Heights Anne Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) 216-44-5878 Director 1 🗆 M 2 😿 F Yrs 65 4/7/47 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2K No Anne Arundel Linthicum 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? Funerai 238 502 Cheddington Rd. 21090 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 end 2 should be filed within 72 hours after of Heeth end Mental Hygiene. Item 27 is marked other then "neturel", or other trsumette event, the Medical Examin ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Evelyn Boone-Steinburg Charles Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 Cheddington Road Charles J. Groskopf Linthicum, Maryland 21090 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Importent: If it sny injury or o once. ŏ 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 4 □ Donation 5 🖾 Other @adombment 8/8/12 Baltimore, Maryland 21. Signature of Funeral Service Ocenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 23a. Part 1. Ent. the disease, of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) KIDNE month Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): inding physician and use as the burial-transit Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Records, P.O. Box 68760 for use es IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year To the Hospital or Attending Physician: The law requires that the des within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed ☐ Yes 2 📉 Yo 1 🗆 Yes Be **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Cher (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ANatural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 defining Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Da) D0036551 6 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EL PRSH 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Facility Name (if not institution, give street and number) **Examiner** If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Director 217-58-0359 1 X M 2 □ F 61 May 16. 1951 Washington, DC show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 X No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 7933 Stone Hearth Road United States 21144 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 ☒ No Black White etc ö ò 1 Never Married 2 Married Maryland 21215-0036 American If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: "natural", 3 Widowed 4 Divorced Completed Indian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 8 Pipefitter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked of r other traumatic ever မ Bonsal Goodrich Genevieve Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Kevin S. Goodrich/Son 169 Carolina Farms Blvd., Calabash, North Carolina 28467 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 August 8. 1 🔲 Burial 2 🙀 Cremation 3 🔲 Removal from State cemetery crematory or other place)
West Arundel 2012 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland Crematory 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.

Donaldson Funeral Home & Maryland 21113 21. Signatur uneral Service Licensee e disease, or complicatio failure. List only one cau that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part 1. Enter 1 shock, or hea Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ -Mous Emphy disease or condition 10 Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to as a consequence of that initiated events use as the burial-trar Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy detached for in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by il or Attending Physician: The law requires that death.

Director: After this certificate has been sign 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniurv 5 Pending Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital of 24 hours at 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Examination of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check To the within To the the only one 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) 30\ Name and address of person who completed cause of death (Item 23a) Date filed (Month, Day, Year, 32. Registrar's Signature State AUG 1 0 201 Registrar

12-05815 Arnetta R. Green	_	Please					nk. Ensur			.egibl	e.			
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Physicia	n/	Registrar  1. Decedent's Name (First, Market)	/liddle,Last)			imodic o	Death		2. Date of D	Reg. No. eath	Num Yul	3. Time of Death		
Medical Examin		Armetta R. G							Month August	Day 4, 2012	Year	0955 hrs		
		4a. Facility Name (if not insti	tution, give street	and number)			4b. City, Town, or	Location of De	eath	40	C. County of D	eath		
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Funeral Director		5. Social Security Number	6. Sex		33 (in yrs. la	st birthday)	If Under 1 Year Months Day		Min		Fo	Birthplace (State or reign MD Country)		
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1215-0036 de filed within 72 hours after death with the Maryland fental Hygiene. arked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	Funeral Director	5041 Pembridge Ave. 21215 J.S.A.												
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N = 2 8		Richard W. G. 19a. Informant's Name/Relati	reene ionship (Type, Pri	nt )		19b. Mailin	g Address (Stree		Jean G			ate Zip Code)		
MD d 2 sho ith and n 27 is		Barbara Greene	∍/Mother			F / 1	Pembridg							
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Baltimore, permit. Pages I an Department of Hea Important: If ited injury or other tra		21 Schature of Funeral Sen	Word !		0	22. N	lame and Address	of FacilityRO	nald Ta	ylor	II Fun	eral H <sup>m</sup>		
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Division pital or Attendit ours after death. eral Director: A	ertification:	3 Suicide 6 C	ould not be 286	e. Place of Inju	ry - At hom	ne, farm, stree	t, factory, office bu	uilding, etc.	28f. Location or Town,		nd Number or f	Rural Route Number, City		
Dospital bours inceral y filled	)  -	4 Homicide		pecify)					1					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burnal control.	<u> </u>	(Check only	Physician: To the xaminer: On the											
To T	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.  29b. Signéture and title of certifier  29c. License number  29d. Date signed (I												
		101,	1 0	/	1		O.C.N				ust 5, 2012			
	-	30. Name and address of person who completed cause of death (Item 23)												
		Zabiullah Ali, M.D.	Assistant N	ledical Exa	miner	900 W. B	altimore Stree	et, Baltimore	e, MD 21223					
		nd Data Start on a death date.		OO Defeterd	0:	4 4								

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 7012 Month August Physician/ Sylvia Greenberg 11:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Min. 217-07-6069 Director 1 □ M 2 🗓 F 99 09/06/1912 MD Usual Residence of Decedent il Hygiene. I other than "netural", or items 23a or 28e-f show vent, the Medical Evaniner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 X Yes 2 ☐ No MD N/A 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3211 CLARKS LANE, #109 21215 USA within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ۵ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ĀNo Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 DENTAL ASSISTANT DENTAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ည BLOCK MORRIS REBECCA MITTMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Depertment of Health ar Importent: if item 27 is eny Injury or other treu once. HARVEY GREENBERG/SON 28 CEDAR HILL ROAD, RANDALLSTOWN, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date Cemetery, crematory
AGUDAS ACHIM
SFARD AHAVAS 1 X Burial 2 Cremation 3 Removal from State 08/08/2012 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD ure of Funeral Service Licensee 21. Sign 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiothrombotic Event Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cardiovascular Disease ATherosciprotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on: Physicien: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last ettending physician Physician/Medical Division of Vital Records, P.O. Box 68760 es the l IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 1 Yes 2 No ed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> cete has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed After this certificete 1 Yes 2 No Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 - Pending injury To the Hospital or Attendin within 24 hours after death.

To the Funerei Director: Aft completely filled In by the fu death. 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

M

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 1 0 2012

NSRajapa Kse MD

MajepaheMD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Smill AV

32. Registrar's Signature

DHMH 17 Rev 06-2011

5 203

29c. License number

00057465

Baltimore MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hopper <sup>M</sup>08 / 10 / 2012 Janice 1:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F 105-24-3442 94 New York Director Yrs Usual Residence of Decedent 28a-f shov ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Rockville MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1235 Potomac Valley Rd United States 20850 hould be filed within 72 nouse and Mental Hygiene.
Is marked other than "natural", or items
"" event, the Medical Examiner m Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by Black, White, etc. 1 Never Married 2 Married Yes Yes, Give 2 No 1 Yes 2 No Specify: 3 ₩idowed 4 ☐ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Professor Academic traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o 2 Edward Harris Esther Korminsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $3605\ R\ Street\ NW\ Washington\ DC\ 20007$ Herman Cohen- Attorney of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 08/10/2012 4 Donation 5 Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licensee 933 Gist Ave 20910 22. Name and Address of Facility Rapp Funeral & Cremation Ser. Silver Spring MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Arrhythmia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease of illijuity that initiated events resulting in death) Last Due to (or as a consequence of): physician are the burial-t Physician/Medical death certificate be attending physical for use as the L IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No Other: ည 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural s after death.

I Director: Aft.

d in by the fun 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

251

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar 29b. Signature and title of certifier

Chablani

Gul G.

Registrar
DHMH 17 Rev 7/2009

11119 Rockville Pike

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Rockville MD 20850

D42518

29d. Date signed (Month, Day, Year)

08/09/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year EMERY F. HERCZEG 111 Medical 2012 8.35 P August 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 9955 Britinay Lane Carney If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Days Hours Director 180-40-8362 XXM2 DF 61 Dec. 29,1950 PA. Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director must be notified 28a-f 1 Yes 2XX No Baltimore County Maryland | Baltimore ö 10g. Citizen of What Country? 23a 21234 USA 9955 Britinay Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 0 by XX Never Married 2 Married XX Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes XX No Specify "natural", Specify: White Completed 3 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 yrs Monumental Life 6vrs Adiuster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o Department of Health and Mental Important; If item 27 is marked any injury or other traumatic evonce. ပ Emery Herczea Anna E, Kranyecz MERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann D. Bowen (Sister) 85 Jumpers Circle Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 8-9-2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. permit. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home J. Las 7401 Belair R d. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nis certificate has to il director, page 2 sl Hospital or Attending Physician: The law r 24 hours after death. Funeral Director: After this certificate has b autopsy performed? death? 2 2 1 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O 20 filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

AUG 10

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year charles Ham's SO PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3007 Wolcott Ave. Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 09-02-1938 Davs Hours **Director** 216-34-4931 1 xxx 2 □ F 73 Usual Residence of Decede filed within 72 hours are tall Hygiene.
ed other than "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show es event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3007 Wolcott Ave. 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Divorced Completed **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/6 condary (0-12) College (1-4 or 5+) Salesman Tastykake other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of Elmer O. Harris Ora Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Barbara Harris/ Wife 3007 Wolcott Ave. Baltimore, MD 21216 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If ii any injury or or 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State MD National Mem.Pk. 8-13-12 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility James A. Morton & Sons F.H., Inc. 21. Algn. ture of Funeral Service Licensee 1701-31 Laurens St. Baltimore, MD 21217 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death hock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ [MEDIOMRUMBONC Event disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cardiovoscular Disease Trenoscerona Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier nskijapamemo 29d. Date signed (Month, Day, Year) D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balhmore MD ZIZO G 5203 NSblajapa Kremp 2835 SMIM AV

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Keisterstown trmore WOOd If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Aug. 5) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 9 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State filed within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at Director Reiste 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or ite Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) TOME permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o ပ Annie Jeffe nomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) way 20b. Place of Disposition (Name of cemetery, crematory or other place 20a, Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8 -10-12 rud 270 21. Signature of Funeral Service Line 23a. Part / Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical -unce of): Due to (or as a cons Examiner Sequentially list conditions, if any, leading to manage the cause. Enter Underlying Cause (Disease or iinjury Examine Due to or as a consequence of To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has performed 2 🗆 No 1 Yes To the Funeral Director: After this certifics completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Aursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 🗌 Yes 2 🗌 No Investigation Accident
Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral L Medical Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month 29c. License numbe 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

12-05479

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK	State of Maryland / Department of Health and Mental Hygiene  1-For State Registrar  Certificate of Death Reg. No. 20   2 255										2 2551		
Physicia ledical Examin		1. Decedent's Name (First, Middle, Kristie Ann Huf							2. Date of D Month	eath Day	Year	3. Time of Death 1904 hrs	
		4a. Facility Name (if not institution,		nt 6	j j	4b. City, Tow		ocation of D	July 21,		c. County of Death		
Funeral			Datamore							Birth(MN	1/DD/YYYY) 9. Bir		
Director			1 M 2 XF	41	Yrs		Days	Hours	Jan.	31,	1971 Foreig	untry)Maryland	
v any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limits	
aryland Sa-f show at once.	ខ្ញុ	Maryland  10e. Street and Number		Ba	altimore	10f. Zip Co	do			10a Cit	tizen of What Cou	1 XYes 2 No	
the Ma Sa nr 28	Director	123 W. Light S	Street			212				_	SA	iu y ?	
215-0036 be filled within 72 hours after death with the Maryland mail Hygiene. rked other than "natural", ar items 23a nr 28a-f ahe mt, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 Never Married 2 Marr	12. Was Decedent E Armed Forces?				( Specify Yes or lerto Rican, etc.)	No-	lo- 14. Race - American Indian, Black, White, etc.				
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of Heal		20a. Method of Disposition  1 Burial 2 Cremation	3 Removal from Stat	e	Place of Disposi crematory or oth	er place)			Date		Location - City or		
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Division of Vital Records, tall or Attending Physician: The law requires at a date death.  1 Director: After this certificate has been a led in by the funeral director, page 2 should the difficult.							_			ormed? 2 N	death?	ompletion of cause of	
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n of Vital Recing Physician: The Land After this certificate Liuneral director, page	t	27. Manner of Death	28a. Date of Injury (Month, Day,Yea		28b. Time of In	ury 28c.	Injury at	t Work?	28d. Describe	how inju	ury occurred	COCITO	
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To the Hospital of within 24 hours at To the Funeral I completely filled		Check only	ician: To the best of my ker:On the basis of examinand manner stated.										
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IX	K	BO. Name and address of person who		•	,					John	22, 2012		
Stat	_   _ 13		stant Medical Exam	Signatu	re	timore Str	eet, B	Baltimore	, MD 21223				
Registra		AUG 1 0, 2012	anna B.	4	are								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nancy Η. Hawes 08706/2012 10:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Wilson Health Care Center Gaithersburg Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 - M 2 X Months Days Hours (Month, Day, Year) 08/06/1918 536-09-6578 **Director** 94 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? 23a Funeral 401 Russell Ave. 20877 United States items ? hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?,
1 Yes 2 No Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No If Yes Give Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NIH Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wellington Wellner Hictchcock Clara Maude Monteith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health if Susan E. Hawes- Daughter 539 Graves Rd. Conway MA 01341 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State FIDE PLUGUE 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licenses 933 Gist Ave. 20910 22. Name and Address of Facility 401585 Koboeca April Rapp Funeral & Cremation Ser. Silver Spring MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final disease or condition Onset and Death Pnysician/ Debility Medical resulting in death) Due to (or as a consequence of): Examiner Alzheimer's Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ned by the atter e detached for u in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be o Peripheral Neuropathy 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy performeda certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a To the Funeral D Hospital Medical 29a. Certifie 🛱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a d title of certi 29c. License number D19294 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Dev. Year)

10 V

Russell Aug.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Peggy Delane James 11:20 a M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 267-52-7588 75 **Director** 1 🗆 M 2 🔀 F 10/09/1936 TN er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Woodstock 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1811 Quarter Horse Drive 21163 United States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ent: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 1 Married ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) စ္ Blane Blevins Pauline McQueen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael D. James - son 1811 Quarter Horse Drive Woodstock, MD 21163 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department Importent: It any injury or once, Crownsville Vet. Cem. 08/13/2012 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CANCER Priysiciam disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 🛕 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of Pertifier 29c. License number 29d. Date signed (Month, Day, Year) D72139 NOMO COLUMBIA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21044 ABBAS MD CEDAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 2:14 Alan Thomas Jones, Sr. August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1525 Galena Road Essex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 214-44-6048 Maryland Director 1 🗷 M 2 🗆 F 08/16/1945 Yrs 66 show 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director or 28a-f sl 1 Yes 2 XNo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 ms 23a or must be Funeral 1525 Galena Road 21221 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Year or Dates. Vietnam 3 Widowed 4 XDivorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the Estimator Electrical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Smith Calvin Earl Jones, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 428 Carroll Island Road, Baltimore, Maryland 21220 Alan Thomas Jones, Jr. Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a Department of h Important: If ite 1 🗌 Burial 2 🛛 Cremation 3 🗌 Removal from State 08/09/2012 injury o Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory 22. Name and Address of Figure 12. Name and Address of Figure Signature of Fundamental Street Licenses 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final muo cardial Physician/ direase or condition reating in death) Medical Due to (or as a consequence of Examiner atherosclero hic Recover tinity list per 3th asif any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed ng physician and as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atten for u in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 🗌 Yes 2 🗌 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: funeral director, Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 🗌 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Certificate: within 24 hours after death.

To the Funeral Director: After injury 5 Pending 2 🗌 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier Notertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 3 🗍 only one) 29b. Signature and title of certifier 0055157  $M \cdot D$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QX1 Point Rd Fort Howard 21052 North SHARON 9600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

12-057	78
Marvin	Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

larvin Jones		State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Reg. No. 2012 255										
Physicia Medical Examin	n/	Marin L. Jones				2. Date of Deat Month August 3,	h Day Year	3. Time of Death 0138 hrs				
		4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or L Baltimore	ocation of Dea							
Funeral	٩	3000 Rosedale Street           5. Social Security Number         6. Sex         7. Age (In yrs. last because of the property).	pirthday)	If Under 1 Year Months Days	If Under 24H	- 3 .	8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign					
Director	-	R12029625 12m 20= 30	in July 1	2,1982	country) MD							
r any	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tov			10d. Inside City Limits  1 Yes 2 No							
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the Ma 3a or 28	Director	2413 Huron St.	l	ISA								
death with the Maryland nr items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 Married 12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No		s Decedent of Hisp es, specify Cuban,		Specify Yes or No- to Rican, etc.)	White, etc.	erican Indian, Black,				
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136 thin 72 hours afterenterenterenterenterenterenterentere	leted	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	ost of working life.	DO NOT use n		Seaford (	34				
15-0036 filed within 72 hours after death with the Maryland I Hygiene. I other than "natural", nr items 23a or 28a-f ahe t, the Medical Examiner must he notified at once	Completed	17. Father's Name (First, Middle, Last)	Toauc	tion Wor		ne (First, Middle, M	<u> </u>	<i>y</i> .				
112 Id be Aenta	To Be	Kooek Jones  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street	oSephi and Number o	ne Hast	nber, City or Town, Sta	te, Zip Code)				
AD 2 sho nand 27 is	-	Josephine Hastings - mother	4907	Gunther tion (Name of cem	Ave. A	pt. J. Br	16. Mb 2/	206 or Town State				
lore, Nages I and to of Health		1 Burial 2 Cremation 3 Removal from State crem	natory or oth	er place)	0	11-12	1 1					
Baltimore, permit. Pages la Department of Ho Important: If ite	ŀ	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility										
Physician	$\dashv$	23a. Party. Enterthe disease, or complications that caused the death. Do	not enter th	ne mode of dying,	such as cardiad	or respiratory arre		Approximate Interval Between Onset and				
/Medical Examiner		failué. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):						Death				
The wife of	_	Sequentially list conditions, b					-					
	Examiner	if any, leading to immediate  Cuse Enter Underlying Course (Disease or injury that initiated  cuse resulting in death). Last  Due to (or as a consequence of):  Due to (or as a consequence of):						-				
i <b>O,</b> e be executed rsician and burial - transit	al Ex	d.		-								
60, nte be ex hysician e burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnant	cy				23d. Date of delive	əry				
Box 6876C death certificate the attending phys	cian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of death	2 Fet	tal death 3 [ ner (Specify)	Ectopic preg	gnancy	Month	Day Year				
J. BOX the death by the atte	Physician/M	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resul			iven in Part I.	23e. Did to	obacco use contribute	to the cause of death?				
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Physicia Physicia er this co	유	27 Manner of Death 28a Date of Injury 28	Outpatient		Other Nur		Residence 6  Oth	er: Scene				
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Divis tal or At as after of al Direc	Certification:	3 Suicide 6 Could not be determined (Specify) Sidewalk	, farm, stree	et, factory, office b	uilding, etc.		Street and Number or I State) le Street, Baltimore	Rural Route Number, City , MD				
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 Certifying Physician: To the best of my knowledge, one) 2 Medical Examiner: On the basis of examination and/o	death occur	red at the time, da	te and place, a	and due to the caused at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)				
To th withi To th	Medical	and manner stated.  29b. Signature and title of certifier		29c. License			29d. Date signed (A					
C CAN		Ling how.	3)	O.C.N	И.Е. 		August 3, 2012					
79		<ol> <li>Name and address of person who completed cause of death (Item 23.</li> <li>Ling Li, MD Assistant Medical Examiner 900 W.</li> </ol>	. Baltimor	re Street, Balt	imore, MD	21223						
St Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Les									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ onnson 08:54AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital 8. Date of Birth If Under 1 Year If Under 24 Hrs. Social Securit Number Age (In vrs. 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day 1 🗆 M 2 🗷 Director 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director notified Yes 2 No Baltimore MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 21216 115A 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes
Yes. Give 1 ☐ Yes 2 No 3 Widowed 4 ☐ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than matic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) omestic Home Be Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Important: If item 27 is marke any injury or other traumatic Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto mo 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Arbutus Mem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature f Funeral Service once. niltentass Balto Mo Part 1. Phiter the disease, or complications that caused the death. Do not enter the should or heart failure. List only one cause on each line. Approximate Interval Between On et and Death Immediate Cause (Final Physician disease or condition resulting in death) 3hock Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Be Completed by Physician/Medical Johnson, Devone Division of Vital Records, P.O. Box 68760 ate has been signed by the attending p page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 1 ☐ Yes ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 \(\sum \) Yes Medical Certificate: 1 Natural 28d. Describe how injury occurred iniury 5 Pending 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: A

completely filled in by the Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 25412 06,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month Year MARGARET EMMA JONES 2012 11:00 PM JIG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ROSSVILLE MANOR CARE ROSEDALE BALTIMORE Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Month, Day, Year) EB. 15,1920 1 M 2 X F Days Min 92 **Director** FEB. 216-12-9522 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD BALTIMORE PARKVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9900 WALTHER BLVD 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. δ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: WHITE "natural" Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) SELF EMPLOYED <u>PIANO TEACHER</u> any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be JOSEPH SAND EMMA LAUDERBACH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAUREEN COPELAND-DAUGHTER 1409 WOODEN BRANCH CT BEL AIR, MD 21012 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PARKWOOD CEMETERY 8/9/12 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, e C 9705 BELAIR RD NOTTINGHAM, MD 21236 23a. Part 1. En. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death obable Venniaum Army Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CHUMAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and bunial-transit Conanan death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the. use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 No for Pregnant at time of death signed by the a d be detached for 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔽 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending injury work? 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

Box 68760 P.O. Records, of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral. Division

State Registrar 29a. Certifier

(Check

lone

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2 1900m

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Alice J. Jones Physician/ August 8, 2012 7:40a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 502 Wycliff Court Harford Joppa 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth If Under **Funeral** (Month, Day, Year) April3,1930 Days 234-46-0607 82 WVA **Director** 1 □ M 2 🔀 F Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The anti-if item 275 is marked other than "natural", or items 23a or 28a-f sho lant: If item 27.5 is marked other than "natural", or items 23a or 28a-f sho uny or or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State Director MD Harford 1 Yes 2 XNo Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 502 Wycliff Court 21085 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry Decedent's Education 16a. Decedent's Usual Occupation Give kind of work doup during most of working life. DO NOT use retired)

Lab Tech (Specify only highest grade completed) Pharmacetical Elementary/Se 4th /Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert S. Gilkerson Effie E. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Stansburge /daughter 502 Wycliff Court Joppa MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 2 Cremation 3 Removal from State Hollt Hill Cemetery 8/10/12 1X Burial Baltimore MD Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Signat Connelly Funeral Home of Essex 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ( < ye brouge wo An disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the buris Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an neral Director: After this certificate has filled in by the funeral director, page 2.3 autopsy performe death? within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify, Hospital: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

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only one)

29b. Signature and title of certifie

Solve Zoo, 4924 Comphell Blok, Batam, Old. 21236 J. 62095, W AUG 1 0 31. Date filed (Month) State Registrar

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

120018758

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 08 058 AM BETH KETTERMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months 214-90-8192 **Director** 1 🗌 M 2 🔀 F Maryland Feb. 10, 1975 37 Usual Residence of Decedent shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a. State Director 1 Tes 2 No Maryland Harford Aberdeen 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21001 4939 Bristle Cone Circle Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2X No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No If Yes, Give White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Defense Contractor Financial Analyst Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Marian Philomena Repetti Alan Samual Ketterman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 552 Kinsale Road, Timonium, MD 21093 Sam Ketterman / Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State Rose Hill Svcs, LLC Bel Air, Maryland 8-13-12 4 ☐ Donation 5 ☐ Other (Specify) na of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MCA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last nding physician by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 mpnths?
1 Yes 2 No Month Year Pregnant at time of death been signed by the s should be detached g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Marbid 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an alopecia ate has page 2 s autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 X No Certificate: To 1 Tes I 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury s after death.

I Director: Aft in by the fur Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1548569791 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 STREET : 310 FLOOR 21201 BALTIMORE, MD SHRUTI M RAJA 110 S PAUA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Maryland		ertment of F <i>tificate of L</i>		Mental Hy	/gieno Reg. No	7111	2 23	520
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and the same of	/Med Exam		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dear	Augus	40	County of Dea	ath	2 A M
	Funera		5. Social Security Number 6. Se		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi	rth	Baltin 9.Bj	rthplace (State	or Foreign
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h with the			10e. Street and Number 929 Back RIVEY	NICK ROAD		10f. Zip Code 2122			10g. Cit	izen of What C	ountry?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menfal Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It is itedical Evanciant must be notified at once.		by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates:	If	/as Decedent of His Yes, specify Cubar □Yes 2⊠No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	)-	14. Race - Am. Black, Whit	te, etc.	<u>_</u>
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Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License			Name and Address	7 7	eral MK		-	Gallana	1212810
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the Hosp	within 24 hours after death.  To the Funeral Director: After completely filled in by the fun	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examine	cian: To the best of my knowled r: On the basis of examination and manner stated.	edge, death oc n and/or inves	ccurred at the time, tigation, in my opin	date and place, ion, death occurr	and due to the c ed at the time, d	ause(s) a ate and p	and manner as place, and due	stated. to the cause(s)	
70	To 1	Σ	29b. Signature and title of certifier	29c. License number 29d. Date signed 29d						signed (Month,	Ionth, Day, Year)	
/	1/	3	30. Name and address of person who com	pleted cause of death (Item 23	Ba) (Type, Prin	1)	Co 1	1101	0	1012	11 01	
	State Registra		31. Date filed (Month, Day, Year)	32. Segistrar's Signature	1	u)	Cauter	, 704		-m D	AM DAI	21221 21231
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:55 P 2012 KOGAN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death KESWICK MULTI-CARE CENTER N/A **BALTIMORE** Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 218-28-2414 Director 1 🕅 M 2 🗆 F 81 Usual Residence of Decedent 03/07/1931 MD 28a-f show with the Maryland at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 6711 PARK HEIGHTS AVENUE, #302 21215 USA hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 1 Never Married 2 X Married "natural", or þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify: WHITE Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) COLLECTIONS AGENT COLLECTIONS and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SAMUEL KOGAN MOLLIE BORSHAY Department of Health an Important: If item 27 is 1 any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONA KOGAN / WIFE 6711 PARK HEIGHTS AVENUE, #302, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BOBROTSKER BENEFICIAL 4 ☐ Donation 5 ☐ Other (Specify) 08/09/2012 ROSEDALE, MD CIRCLE CEMETERY 21. Sign ure f Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death O M ON HAS Immediate Cause (Final Intellyrating Ph\_sician/ aroun tunior disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ leion 403 arcoma 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed inal tract 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗌 No Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 W No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending 1 Yes 2 No the ☐ Accident ☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State)

s after death. within 24 hours a

To the Funeral C

completely filled

State

Medical

29a. Certifier (Check

3 🗌

or Babelle

29b. Signature and title of certifier

AUG 1 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Moega 700W.40% STREET, BALTO. MD 21211 EGOR 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

ARI MA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

013657

29d. Date signed (Month, Day, Year)

august 8, 2012

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per PHY G930 8/21/2012 JH State of Maryland / Department of Health and Mental Hygiene 20 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09 3. Time of Death Physician/ Month Arrie Mae Long 2012 Medical August a 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Days Hours Director 219-30-1732 1 □ M 2 X F 3-3-1926 SC 86 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1 🔽 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 USA 5005 Overton Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. SpecifAfrican-American Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9th Fellows Welder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth Barnes Porter Foreman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5005 Overton street, Baltimore, MD 21229 Wynoina Simms/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, MD King Memorial Park 8-17-2012 AUGUST 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Wille Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed the attending physician and shed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Dav Year 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy After this certificate Yes 2 N No filled in by the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🕱 Other (Specify) HOSPICE 1 ☐ Yes 2 👿 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Director 3 Suicide
4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by City or Town, State, Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitionum: To the basis of my knowledge, death occurred at the time, date and place, and due to the name (s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 ハニ 43725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6V TARIQ MAHMOOD, MD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State Registrar 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $_2$   $_{\cap}$ Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DRSI Month 20 12 01:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWAR If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 216 20 1511 **Director** 1 🗆 M 2🄀 F 10-12**-**1926 Maryland 85 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiem 27 is anaward other than "natural;", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Ellicott City Howard MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21042 3206 Hearthstone Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married <u>გ</u> 1 Yes 2 KNo
If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ₩ Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Angela Savaliski Charles Lacie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence L. Lehrer III/Son 3206 Hearthstone Road Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Johns Cemetery 8-13-2012 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition claus Medical resulting in death) Due to (or as a consequence of): Examiner pneu Maria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami ig physician and as the burial-transit Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day after death.

Director. After this certificate has been signed by the a librector. After this certificate has been signed by the and in by the funeral director, page 2 should be detached. 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \sum \) Nursing Home \( 5 \sup \) Residence \( 6 \sup \) Other (Specify) ည 1 Tes 2. No 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ò filled in within 24 hours af To the Funeral D completely filled i To the Hospital Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) Coleman. Leclar laue 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

AUG 1 0 2012

32. Registrar's 6ignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2012 8:15 Ам August Leo Marvin Lake Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Harford Forest Hill Forest Hill Nursing Home 9. Birthplace (State or Foreign 8. Date of Birth If Under 24 Hrs If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. June 13, . 1928 1928 Pennsylvania 1 X M 2 🗆 Yrs. 216 24 7726 84 **Director** Usual Residence of Decedent 10d, Inside City Limits items 23a or 28a-f show her must be notified at 10c. City, Town or Location 10a. State 10b. County 72 hours after death with the Maryland Director 1 Yes 2 X No Harford Fallston Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA Funera 21047 3013 Reckord Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ed other than "natural", or ite event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 7 No45/47 If Yes, Give 1945/47 þ White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Construction Bricklayer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Anna Steach Elbert Fleo Lake Page 1 and 2 should ment of Health and Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3013 Reckord Rd. Fallston, Maryland 21047 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Andrea Lake (Daughter in Law) injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory Inc. 8/10/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home\_P.A. 21. Signature of Funeral Service License any Maryland 21221 1407 Old Fastern Avenue Essex oft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Th disease or condition resulting in death) 50 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Dav 5 Other (specify) Yes 2 No **Director:** After this certificate has been signed by the a in by the funeral director, page 2 should be detached 9 Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director; After this certificate has b autopsy performed? 26. Place of Death (Check only one) **Division of Vital** Be 25. Was case referred to medica Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

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the

DAVIN

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State Registrar

31. Date filed (Month, Day, Year) AUG 1 0 2012

2 \_

29b. Signature and title of certifie

(Check

only one)

615 W 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M98/04/2012 3:35 Ам Carol Lindquist Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Apt# 104 Montgomery Chevy Chase 5100 Dorset Ave 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 M 2 X Months 87 02703/1925 **Director** 375-20-5995 MI Usual Residence of Decedent works 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Chevy Chase Montgomery 28a-f MD 1 🛮 Yes 2 🗆 No 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? "natural", or items 23a or Funeral 20815 United States 5100 Dorset Ave. Apt# 104 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ should be filed with h and Mental Hygien **7 is marked** ot**her ti** Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew L. Eldridge Blanche Wetherell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean C. Duley- Daughter 5100 Dorset Ave. #104 Chevy Chase MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2 Cremation 3 Removal from State 08/06/2012 |Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 933 Gist Ave. 22. Name and Address of Facility 20910 101585 Rapp Funeral & Cremation Ser. Silver Spring MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Aortic Stenosis Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Exami Cause (Disease or linjury Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Box 68760 attending p as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death the P.O. ed by Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. signed det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Esophageal Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 s autopsy performed? 2 No 1 Yes 2 X No certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: At ampleted filled in by the fu Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homici determined

within 2 To the F عا

n who completed cause of death (Item 23a) (Type, Print) 30. Name and addres

David E. Rogers 5530 Wisconsin Ave #1400 Chevy Chase MD 20815

State Registrar

Medical 29a. ertifier

heck

and title of

29b. Signatu

AUG I O

**ORIGINAL** 

Certifing Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

D50030

Med al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

08/06/2012

29c. License number

12-05760 Mollett, III Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK		- For State	ate of Maryla		epartme Certifica				Menta	al Hy		eg. No.	21		2 2552	2
Physicia		<b>Registrar</b> 1. Decedent's Name (First, Midd	e,Last)							2	. Date of Dea	th	Year	3	. Time of Death	٦
ledical Examin	er	Joseph William Mo									Month August 2,				1305 hrs	
		<ol> <li>Facility Name (if not institution</li> <li>4200 Primrose Avenu</li> </ol>		nber)		41	Baltim		ocation of	Death			. County of			
Funeral	1	5. Social Security Number	6. Sex	7. Age (In	yrs. last birth	nday)	If Under		If Under	_			DD/YYYY)	9. Birth Foreign	place (State or	
Director		215-86-3726	1 M 2 F		47	Yrs.	Months	Days	Hours	Min.	9-7-19	964		Cour	try) MD	
	-	Usual Residence of Decedent		Lin	City, Town o	!									0d. Inside City Limits	_
W 80y		10a. State 10b. County  MD n/	'a	100.	•										1 Y Yes 2 No	
Aaryland 28a-f show	힐	MD n/	a ————		Baltimore 10f. Zip Code							21	_			
th the Maryland 23a or 28a-f sho ootified at ooce.	Director	3725 Chesholm	Road					21216			10g. Citizen of What Country?  USA					
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "oatural", or items 23a or 28a-f sherot, the Medical Examiner must be ootified at goes	_ L	11. Marital Status	12. Was Dece	edent Ever	in U.S.	13. Was			nic Origir	1? ( Spe	cify Yes or No	)-	14. Race -		ın Indian, Black,	-
eath v	Funera		1 Never Married 2 Married Armed Forces?			If Ye	s, specify	Cuban, N	Mexican, F	Puerto R	ican, etc.)		White,			
after d	ð.	3 Widowed 4 Div	orced If Yes, Give Year		X No 1 Yes 2 X No specify:										n-American	
oatur:		15. Decedent's Education (Spe	cify only highest grad			Decedent's during mos						16b. k	Kind of Bus	iness/Ind	lustry	
36 hin 72 h e. than "edical F	Completed	Elementary/Secondary (0-12)	College (1-	-4 or 5+)		CI.							TTAT	,	222	
15-0036 filed within 72 Hygiene. d other than the Medical	E	10th 17. Father's Name (First, Middle	Last)		<u> </u>	<u>one</u> Sh	orena		.Mother's	Name (	First, Middle,		IIA Lo Surname)	cal .	333	-
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ceven, the Medical	Be	Jospeh W. Mollett						_   ,	Camly	m Wi	mllev					
D 21; should b and Men 7 is mar	2	19a Informant's Name/Relations	ship (Type, Print)		19b	. Mailing	Address	(Street a	and Num	er or Ru	ndlev ral Route Nu	mber, Ci	ity or Town	State, 2	Zip Code)	
e, MD 2121 ( I and 2 should be file Health and Mental H item 27 is marked r traumatic evees, t		Rosanna Mollett/	Wife		3	3725 C	hesho	lm Rd	. Bal	ltimo	ne, MD 2 Daté	21216	Location - 0	Situ or T	own State	_
nore, MC ages I and 2 s nn of Health an		20a. Method of Disposition  1 X Burial 2 Cremation	n 3/ Removal fro		cremato	ory or othe	er place)					1			JWII, JUAICE	
Page Page ment o		4 Donation 5 Other S	pecify:	2	King N	Amori	al Pa	rk ———		3-13-			dlawn,		alto. Co.	_
Baltimore, permit. Pages la Department of He Important: If its injury or other injury or other in	1	21. Synature of Funeral Service	Icensee							-7	llstown,			he footbelle	Pillo. Qi.	
Physician	+	23a. Part I. Enter the disease, of	complications that ca	aused the c	death. Do no	t enter the	e mode of	dying, su	uch as car	rdiac or	respiratory ar	rest, sho	ock, or hear	t	Approximate Interval	1
Medica		failure. List only one cause Immediate Cause (Final disease	on each line.											- 174	Between Onset and Death	
Examiner		or condition resulting in death)	Due to (or as a													_
and the second	اي	Sequentially list conditions,	b Due to (or as a	consequio	nce of):									-		-
	jë.	if any, leading to immediate cause. Enter Underlying Cause														
ig id	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseque	nce of):											
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60, ate be thysici		IF FEMALE:	23c. If yes, o	outcome of	pregnancy			_				230	d. Date of d	lelivery		-
Box 68760 death certificate be attending physical dor use as the bu	Physician/Me	23b. Was decedent pregnant in t past 12 months?	Drogn	irth ant at time	of 2		al death	3	Ectopic	pregnan	су		Month	Da	y Year	
- u - u	sic	1 Yes 2 No 9 Un	known 9 Unkno		5	Oth	er (Spec	fy)								1
that the de ned by the detached the		Part II. Other significant condi	tions contributing to	s contributing to death but not resulting in the underlying cause given in Part I.						t I.	23e. Did tobacco use contribute to the cause of death?					
e e	Completed by	Cocaine Use									1 Ye	s 2	No 3	Proba	bly 4 ✓ Unknown	
ords, F	ete										24a. Was				psy findings available mpletion of cause of	
of Vital Records, og Physiciae: The law requir Nher this certificate has been s meral director, page 2 should	티										perfo 1 ✓ Yes	ormed? 2 N		eath?	2 No	
tal Re(ino: The certificate	BeC	25. Was case referred to medical					2		of Death (	Check o	nly one)					_
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ing Physical After this funeral dir		27. Manner of Death  1 Natural 5 Pen		of Injury Day,Year)	128b.	Time of In Ind	jury 2		at Work? es 2 🗶	- 1	28d. Describe Inknowi		ury occurre	ď		
IVISION or Attence after death Director:	iğ		sugation	<b>-2-12</b>	L2:	50 pr				-			and Numbe	r or Rur	al Route Number, City	
Division pital or Attendii ours after death.	Certification:	dete	old not be sermined (Specify)	-	nd:Mo		i, lactory,	Office but	ildiilig, etc						ose Ave.	
E 6 5		4 Homicide  29a. Certifier 1 Certifying F	hysician: To the bes	t of my kno	owledge, dea	ath occurr	ed at the	time, date	e and plac	ce, and o	due to the cau	ıse(s) ar	nd manner	as state	i.	-
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exa	aminer: On the basis of and manner s	of examina	tion and/or i	nvestigati	on, in my	opinion,	death occ	urred at	the time, date	e and pla	ace, and du	e to the	cause(s)	
₩ F 3 F 8	Me	29b. Signature and title of certifi			/	12	29c	License							h, Day, Year)	
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U		Russell Alexander Mi		gistraris S		900 \	v. Balt	more S	orreet, l	oaitim:	ore, MD 2	1223				_
Sta Regist	ate	31. Date filed (Month, Day, Year	2012	rylod area o	igi iatul e	L	. Ale	)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year monks Loss Thompson PURUST 1013014 M Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Madonna Heritage, Inc Jarrettsville Harford Funeral Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Hours Director 220-20-7592 1**X** M 2 □ F Yrs 86 July 23, 1926 Usual Residence of Decede Maryland 28a-f shov 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 1

Yes 2 □ No Maryland Harford Bel Air 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a must I 213 B Crocker Drive 21014 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Maintenance Worker State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John William Monks Hazel Irene Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Linda J. McElwain / Daughter 5244 Carea Road, White Hall, MD 21161 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Churchville Pres. Cem. 8-13-2012 Churchville, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ASCUD cars Medical resulting in death) Due to (or as a consequence of): Examiner ナナイ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying leaves Examine Due to (or as a consequence of) Din Cause (Disease or injury that initiated events 1ear resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical 68760 as the IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant Box ( 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Chronic Kidney diseases Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? hypothyroid 24a Was an autopsy performed? ancmin 2 🗌 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No the Hospital or Attending Physician; of Vital Be 26. Place of Death (Check only one) 10-55 is teil to us Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural iniury Division within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu Accident
Suicide investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner To the best of my knowledge, death occurred at the time, day and place, and due to the cause(s) and manner stated. at the time, date and place, and due to the 29c. License number D 31296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/206 5701 Kenwood Date filed (Inth, Day, Year) 32. Registrar's Signature State 0 2012 AUG Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 5, Day 2012 Physician/ Sylvester Mitchell 5:00 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Cheverly Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 579-50-6866 1X M 2 | F 73 Washington, DC 12-27-1938 Usual Residence of Dec ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 🔀 Yes 2 🗌 No Md. P.G. Forestville 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? Funeral 20747 3714 Walters Lane U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. the Medical Examiner Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. P 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black "natural" Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than, should be filed within 7 and Mental Hygiene.
7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th Contractor Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mitchell J.B. Metts or other traumatic Louise 1 and 2 should be the Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ester Best Mitchell - Wife 3714 Walters Lane, Forestville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) ■ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 08-14-2012 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ronald Taylor II Funeral Home Koovos 10583 Middleport Lane, White Plains, Md. 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ Hepatic metastasis disease or condition Medical resulting in death) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and -tran: burial-t resulting in death) Last Due to (or as a consequence of) ng physician as the burial Physician/Medical that the death certificate be Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Month Year Pregnant at time of death Yes 2 No detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, ongestive heart tailure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform 1 ☐ Yes 2 X No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မူ Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending ours after death. leral Director: Ai filled in by the fu 1 🔲 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatu 0-022990 ospital DR Chiverly Mn 20786 State AUG 1 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201<sup>2</sup> August Mary Mason 8:57 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1906 Village Green Drive Hyattsville Prince Georges If Under Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours Director 1 🗆 M 2 🔀 577-72-1155 70 March 2,1942 South Carolina Usual Residence of Deced works: 10d. Inside City Limits 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Md. Hyattsville P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1906 Village Green Drive 20785 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black White etc 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural" Specify: 3 Widowed 4 ☐ Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Private Pantry Keeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sumpter Grant Maggie Workman other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 1906 Village Green Dr., Hyattsville, Md. 20785 Jestine Mason - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State i ii. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Lincoln Cemetery 08-15-2012 Brentwood, Maryland . Signature of Funeral Service License 22. Name and Address of Facility Ronald Taylor II Funeral Home 10583 Middleport Lane, White Plains, Md. 20695 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, ici n Coronary Artery Disease Medica! resulting in death) Due to (or as a consequence of Examiner Parkinson Disease Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury Diabetes Mellitus Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Hypertensive Heart Disease Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No After this certificate has , page 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 **X**No Other: 4 Nursing Home 5 🔀 Residence 6 🗆 Other (Specify) Hospital: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA thin 24 hours after death.

the Funeral Director: After this

mpletely filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within To the 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D46998 August 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD - 3415 Hamilton Street, Hyattsville, Maryland Steven Tee,

Registrar

**State** 

31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 3 State of Maryland 2 Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month /08/2012 Ruth Baldwin Maletta 7:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maplewood Park Place Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 023-03-4114 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Director 1 □ M 2 🕱 F 100 08/10/1911 Michigan iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Bethesda Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral death with 9707 Old Georgetown Rd. Apt#106 20814 United States 12. Was Decedent Ever in U.S. Armed Forces?. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married within 72 hours after Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. Specify: 3 X Widowed 4 □ Divorced "natural", Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Private Schools Teacher Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) |Henry Fay Baldwin Eleanor L. Turner permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19**3 later Parts** Name/Relationship (*Type, Print*)

Jeffery Maletta- Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 36th Street NW Washington DC 20007 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 08/10/2012 Beltsville, MD 4 Donation 5 Other (Specify) 933 Gist Ave 20910 21. Signature of Funeral Service Licen 22. Name and Address of Facility Rapp Funeral & Cremation Ser. Silver Spring MD Kar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Debility Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Gause (Disease or Injury nding physician and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) atten for u in the past 12 months?

1 Yes 2 No Day Pregnant at time of death the the Unknown been signed by t should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed? 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Hospita Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bowtie$  Other (Specify) 1 Yes 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA ျ LIVENS 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

n 24 hours after death.

e Funeral Director: After th
bletely filled in by the funeral

State Registrar

Medical

4 Homicide

29b. Signature and title of certifier

Joceli

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4140 Powder Mill Rd. #600 Belsville MD 20705

Koucel

determined

Jocelyne T. Kouatchou MD

29d. Date signed (Month, Day, Year)

2

31. Date filed (Month, Day, Year) AUG 10

chou

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D6374 8

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08nth 08 20°f°2 Carrie Marie Nott 7:14P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 215-44-1899 Director 1 M 2 N F 8/16/1943 68 Pa Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Carroll Westminster MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 USA 381 Buck Cash Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify. should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) LPN Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mchree E. Miller William Walter Nott e 1 and 2 should b of Health and Mer If item 27 is mark or other traumation 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 381 Buck Cash Dr., Westminster, MD 21158 Gerald Goldsmith-son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If its any injury or of 1 Burial 2 Cremation 3 Removal from State Winfield South Carroll Crem 8/13/12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur uneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home, P.A. Main St., Westminster, MD 21157 254 Ε. 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final scheni ₽nysician/ CAZDIOMY Opt M 4 Q4n disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liner underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): ŵ resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31660 9/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LNRS MIRSTER MAKELE HOWAS STONEL AVENUE

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 09 11:00 AM 2012 Rose Marie Novak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center for Hospice Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 219-60-9672 Director 1 □ M 2**½** F 60 04/21/1952 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Middle River Baltimore 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13117 E. Greenbank Road 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 🗌 Yes 2 🔀 No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Associate Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Young Rose Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Charles Novak (Husband) 13117 E. Greenbank Road, Baltimore, Maryalnd 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State Bayview Crematory, Ind 08/10/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Significant of Fundal Service Livensee 22. Name and Address of Eacility
Pruzdzinski Funeral Home, P.A Maryland 21221 1407 Eastern Avenue. 29a. Fait 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition relation to the condition of the Approximate Interval Between Onset and Death Friysician/ Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): after death. Director: After this certificate has been signed by the attending physician and 1 n by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed ause (Disease or mjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 | Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မူ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28d. Describe how injury occurred 5 Pending injury Accident Investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours aft

To the Funeral Di

completely filled in Medical 1 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signatu 29d. Date signed (Month, Day, Year) D007128 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \*4105, Baltimare. 6701N haheen (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:00р м Anna M. Peltzer 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Middle River 3500 Glenwood Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 18, 1923 Funeral 5. Social Security Number 216-16-1374 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours  $88_{Yrs}$ **Director** 1 1 M 2 X F MD Usual Residence of Decede Department of Health end Mental Hygiene important, or items 23a or 28a-f show important: if item 27 is marked other than "netural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b Count 10c. City, Town or Location
Middle River 10d. Inside City Limits Director Baltimore MD 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 21220 3500 Glenwood Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, δ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give White 1 Yes 2 No Specify: Specify: 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Peltzer Sport Elementary/Secondary (0-12) College (1-4 or 5+) Owner 12th Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna E. Prui Page 1 and 2 should be George E. Knapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 Bowleys Quarters Road Balto. MD 21220 Peggy Tawney /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 8/13/12 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 21. Signature Funeral Tervic Licens 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of sician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death between within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burian Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical Be Division of Vital 26. Place of Death (Check only one) examiner? Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work?
1 Yes 2 No 5 Pending Investigation Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and ad of death (Item 23a) (Type, Print) State 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 06, Physician/ 2012 2:40 P M PANITZ STANLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SPRINGWELL ASSISTED LIVING N/ABALTIMORE Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours 1X M 2 □ F (Month, Day, Year) 11/18/1923 MD 88 Director 219-16-8237 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location death with the Maryland Director 1 Tyryes 2 I No MD N/ABALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 108 ST. JOHNS ROAD 21210 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. "natural", or ۵ م 1 Never Married 2X Married 72 hours after Baltimore, Maryland 21215-0036 1 🗆 Yes 2 No If Yes, Give Year or Dates WHITE 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 m. In and Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) EXECUTIVE BUILDER/DEVELOPER other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ PANITZ ANNA BERMAN GILBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau CAROLINE HAMBLETON PANITZ/WIFE JOHNS ROAD, BALTIMORE, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2X Cremation 3 Removal from State DRUID RIDGE CEMETERY 09/09/2012 4 Donation 5 Other (Specify) BALTIMORE, MD 22. Name and Address of Facility Signature of Euneral Se Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) detached 9 I Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed 1 ☐ Yes 2 ☐ No Yes 2 certificate al or Attending Physician: after death. eral Director; After this certific filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? ASSISTED LIVING Other: 4 Nursing Home 5 Residence 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 28c. Injury at work?
1 Yes 2 No iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completed filled Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Exertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year) AUG 10

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29b. Signature and

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RO 70246

North Charles St. Baltimore MD 21204

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Keinhardt **Physician** harles 2012 06 4UG /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BALTIMORE AGNES HOSPITAL 9. Birthplace (State or Foreign Country)

North Carolina If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 □ F Months Days Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside Sity Limits 10a State th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Framiner must be notified at 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WICKON 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Keinhardt tauline Harrison ပ 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wicklow Rd. Battimore of Health a Chandra Reinhardt -daughter Department of Health Important: If item 27 any injury or other transce. 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/15/12 Owings Mills, Maryki 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee rederick Ave. Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Du to (or as a consequence of) Examiner RSISTEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner PAILURE attending physician and for use as the burial-tran Hospital or Attending Physlcian: The law requires that the death certificate be execu Division of Vital Records, P.O. Box 68760, SCHEMIC TROKE IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? funeral director. B 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ↑☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) AUG | 6 | 2012 29c. License number D0054257 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATON AV BALTIMORE-21229 HARMA 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G930 8/17/2012 JH State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Nathaniel Joseph Rybkin 13:SL PM 10:2 Medical Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death ta C Ihmo 5 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. **Funeral** 52-5016 9. Birthplace (State or Foreign Hours Director 1 M 2 - F 8/4/12 MD or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 No Carroll MD Westminster 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 470 Avenel Cir., Apt 102 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 ¹∑Yes 2□No Specify:Guatemalan "natural" Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) if Health and Mental Hygiene. item 27 is marked other tha other traumatic event, the I Infant Infant Be permit. Page 1 and 2 should be file.
Department of Health and Mental H.
Important: If item 27 is marked any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Paul Rybkin Karen Rodas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Rodas-mother 470 Avenel Cir., Apt. 102 Westminster, 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/8/12 Winfield Carroll Cremi. 4 ☐ Donation 5 ☐ Other (Specify) South 21. Signatur 22. Name and Address of Facility Fletcher Funeral Home, P.A. Service I censee Main St. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final asia Physician PG disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director. After this certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death

1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred injury 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) within 24 hours a

To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year, 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANKHANA nth, Day, Year) State Registrar

12-05813 Gregg Reed Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 25537

		1- For State Certificate of Death		Reg. No.	
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last)	Date of De Month	Day Year	3. Time of Death
viculcai Examii	ıçı	Greg Reed  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location or	August 4		0717 hrs
A STATE OF THE STA	6	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of 6897 Statum Road  Preston	r Death	4c. County of Dea Caroline	atn
Funeral	٦	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	r 24Hrs. 8, Date of 8		Birthplace (State or
Director		190-42-6754 1 N 2 F 57 Yrs. Months Days Hours	Min. 10/21	Fore	eign Country) PA
Any	ŀ	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location		-	10d. Inside City Limits
<b>*</b>	_	Maryland Caroline Preston			1 Yes 2 No
faryla 28a-f	Director	10e. Street and Number 10f. Zip Code	Ī	10g. Citizen of What Co	ountry?
vith the Maryland s 23a or 28a-f sho e notified at once		6897 Statum Road 21655		USA	
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican,		Io- 14. Race - Ame White, etc.	erican Indian, Black,
rafter	2	3 Widowed 4 Divorced If Yes, Give Year or Dates:			hite
	g.	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give k during most of working life. DO NOT usual occupation)		16b. Kind of Busines	s/Industry
215-0036 be filed within 72 hantal Hygiene. rked other than "m.	Completed	12 n/a		n/a	
5-00 lled wit Hygien I other	녌		s Name (First, Middle,		
21215-00; uld be filed with Mental Hygiene, marked other to	Be		nica Robin		25-25-25-26-26-27-20
20.34	잍	19a. Informant's Name/Relationship (Type, Print)  Mary Beth Edwards / Sister  19b. Mailing Address (Street and Numb  237 West Maple Ave			
	-	Mary Beth Edwards / Sister 237 West Maple Ave	Date Date	20c. Location - City	
		1 Burial 2 X Cremation 3 Removal from State crematory or other place)			
Baltimore, permit. Pages I a Department of He Important: If ite	1	4 Donation 5 Other Specify: Metro Crematory, Inc. 21 Signature of Funeral Service Licensee Stephanie Cister 22. Name and Address of Facility	08/07/201	2  Baltimore	,Maryland
Ba perm Depa Impo		Otopiom a Culls 299 Frederick F			
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca			Approximate Interval
Examiner	1	failure. List only one cause on each line.  Immediate Cause (Final disease a, Atherosclerotic Cardiovascular Disease			Between Onset and Death
Mode Parkallinia		or condition resulting in death)  Due to (or as a consequence of):			
	ā	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):			
	Examiner	Course Enter Underlying Causs (Disease or injury that initiated			3
or d d ansit		events resulting in death) Last Due to (or as a consequence of): d.			
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED #1as noted, perME.G930,8/17/2	2012 WS		
760, icate be physici the buri	₽ŀ	IF FEMALE: 23c. If yes, outcome of pregnancy	2012,W3	23d. Date of delive	егу
ox 687 eath certific attending p		23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic	pregnancy	Month	Day Year
Box 68  c death certif  the attending  ed for use as	Physician	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)			
O. B at the da 1 by the tached i		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	t I. 23e. Did	tobacco use contribute t	to the cause of death?
	و و		1 Ye	es 2 No 3 Pr	obably 4 🗹 Unknown
ords, P w requires t us been sign should be d	Completed		24a. Was		autopsy findings available completion of cause of
Recc The lav icate ha	E		perf	ormed? death?	
tal Rection: The certificate ector, page	0	25. Was case referred to medical examiner?			
'hysic	P P	1 Yes 2 No Inspired 1 Inpatient 2 ER/Outpatient 3 DOA	Nursing Home 5		er: Scene
ion of Vital   tending Physician: eath. tor: After this certifi the funeral director,		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 ✓ Natural 5 Pending	i	how injury occurred	
SiOl Atten death ector:	討	2 Accident Investigation			
Division of Vital Records, pital or Attending Physician: The law require ours after death.  The law rectuir after this certificate has been sifilled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town,		Rural Route Number, City
bou hou y fill	- 1	4 _ Homicide	ce, and due to the cau	use(s) and manner as sta	ated.
To the How within 24 h	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.		' '	
F3F8	<b>ĕ</b>	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	Ionth, Day, Year)
		(2(111119) O.C.M.E.		August 5, 2012	
181	Ì	30. Name and address of person who completed cause of death (Item 23a)  Zobiullah Ali M.D. Acciptant Medical Examinary 200 M. Politimary Street Politics	MD 04000		
		Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltin	nore, MD 21223		
Sta Registr	ιe	31. Date filed (Month, Day Year) 32. Registrary Signature			

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Russell Robins		State of Maryland / Department of Certificate or			2012 2553							
hysician/ Medi	ical	1. Decedent's Name (First, Middle,Last)		Reg. No.  P. Date of Deeth  Month Day	3. Time of Death							
Exam	iner	Russell Michael Robison		July 31, 2012	0828 hrs							
			4b. City, Town, or Location of Death Baltimore		County of Death  / a							
Funeral Director		5. Social Security Number 216-02-0152 6. Sex 1 \bigsep 1 \bigsep 31 \bigsep 31 \bigsep 31 \bigsep 7. Age (in yrs. last birthday)	Months Deys Hours Min.	8. Dete of Birth (MM/D 04/14/198	Country)							
any		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location	02		10d. Inside City Limits							
À		Maryland n/a Baltimore			1 XYes 2 No							
Maryland 28a-f show	Director	10e. Street and Number	10f, Zip Code		en of What Country?							
the M		3721 South Hanover Street	outh Hanover Street 21225 USA									
th with	Funeral		is Decedent of Hispanic Origin? (Spec res, specify Cuban, Mexican, Puerto Ri		14. Race - American Indian, Black, White, etc.							
er dea , or it	교	1 Yes 2 No	Yes 2 X No specify:		Specify: White							
ours aft atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Deceden	t's Usual Occupation (Give kind of work	done 16b. K	ind of Business/Industry							
6 172hc an "na	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use retired		. 1							
.003 within giene.	Completed	12 Barte	nder/cook	Cas irst, Middle, Maiden Si	tle Restaurant							
21215-0036 uld be filed within 7 Mental Hygiene marked other than cevent, tre versions	Bec	Russell Robison	Karen Pet		mansej							
- 3 5 2 T	10		Address (Street and Number or Ru									
e, MD 2 1 and 2 shou Health and 1 item 27 is r		Karen Robison 3721  20a. Method of Disposition 120b. Place of Disposi		more, Maryland 21225								
Baltimore, cernit. Pages 1 ar Department of Hea Important: If the Injury or other tr		1 Burial 2 Cremation 3 Removal from State crematory or ot	her place)									
Baltimore permit. Pages 1: Department of Hi Important: If it injury or other t			matory, Inc. 08/09  Jame and Address of Fecility Crema									
Ba Perm Depa Imp			9 Frederick Road									
Physician		23a. Part I. Enter the disease, or complications that caused the death, Do not enter the failure. List only one cause on each line.	spiratory arrest, shock	or heart Approximate Interval Between Onset and								
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a Gastrointestinal herr  Due to (or es a consequence of):	orrhage due to va	ariceal dis	sease Death							
		Sequentially list conditions,										
	iner	if any, leading to immediate ————————————————————————————————————										
42	Examiner	(Disease or injury that initiated c. events resulting in death) Last ue to (or as a consequence or).										
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50, tebee	Medical	INPENDED AMENDED #4 per th, # 1 as 9-28-12 sm  1F FEMALE: 23c. If yes, outcome of pregnancy	, noted, 25a, per 11,	23d	Date of delivery							
Box 68760, a death certificate be the attending physic ed for use as the bur	_	23b Was decedent pregnant in the past 12 months? 1 Live birth 2 Fel	tal death 3 Ectopic pregnenc		Month Dey Year							
Sox 687 death certifit eattending	Physician	4 Pregnant at time of death 5 Off	ner (Specify)									
D.O. Bothat the desired by the second detached for	P.	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?							
s, P.O.	d by	Hypertensive cardiovascular Disease	2	1 Yes 2	No 3 Probably 4 X Unknown							
cords, Plaw requires that become the control of the	plete	Chronic alocoholism		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Completed by			performed?  1 X Yes 2 No	death? 1 X Yes 2 No							
ital Recicion: The scertificate irector, page	B	25. Was case referred to medical examiner?  Hospital 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check onl 3 DOA Other Nursing I									
of Vit g Physic fler this	욘	1 X Yes 2 No 1 I I I I I I I I I I I I I I I I I I		nome 5 Residen  8d. Describe how injur	ce 6 X Other Scene y occurred							
ion of tending Pheat or; After the funeral	팋	1 Natural 5 Pending Accident Investigation (Month, Day, Year)	1 Yes 2 No									
Division p tal or Attenda ours after death teral Director; A	ertification:	3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street	et, factory, office building, etc. 28	8f. Location (Street an or Town, State)	d Number or Rurel Route Number, City							
D sptal hours meral y filled	S	4 Homicide determined (Specify) 29a. Certifier 1 Countries Physician Talloude (Specify)										
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation										
To To con	Mec	and manner stated  29b. Signature and title of certifier	29c. License number	29d D	rete signed (Month, Day, Year)							
		The Mr. M. To	O.C.M.E. OCME	Ju	ly 31, 2012							
		30 Name and address of person who completed carrie of death (Ifem 23a)	<i>C</i> -1									
10			00 W. Baltimore Street, Baltin	nore, MD 21223								
Si Regis	tate trar	31 Date filed (MANUGay) Yell 2012 32. Tegistrar's Signature	del									
DHMH 17 Rev 1/20	001	ORIGINA	L									

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Maria Teresa Sagardia	State of Maryland / Department of Health and Mental Hygiene		0.01	0	
1- For State Registrar	Certificate of Death	Reg. No.	201	2	2553
Physician/ 1. Decedent	s Name (First, Middle, Last) 2. Date of	Death		3 Tim	ne of Death

		- For State	Certi	ficate of L			Re	eg. No. 20	12 2553
Physicia	n/	Decedent's Name (First, Middle,Last)	1: -				2. Date of Dea Month August 6,		3 Time of Death 1910 hrs
Medical Examir		Maria Teresa Sagaro  4a Facility Name (if not institution, give street		4b	. City, Town, or	Location of D		4c. County of D	
3	<b>,</b> .	11630 Glen Arm Road #1 AL24			Glen Arm			Baltimore (	
Funeral Director	- 1	5. Social Security Number 6. Sex 213-20-7788 1 M	7. Age (In yrs. last $2X$ F $10$		If Under 1 Yea Months Day		Min. 8. Date of Bir 12/15	F	Birthplace (State or preign Puerto Country) Rico
áue	- 1	Usual Residence of Decedent  10a. State 10b. County	10c. City. To	own or Location	1				10d. Inside City Limits
*		Maryland Baltimore	Glen						1 Yes 2X No
Aaryland 28a-f show		10e. Street and Number			10f. Zip Code	_	1	0g. Citizen of What	Country?
th the Marylanc 23a or 28a-f sh notified at onc		11630 Glen Arm Road			2105			USA	
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Fitem 27 is marked other than "natural", or items 23a or 28a-f shorr traumatic event, the M-is al Examiner must be notified at once.	Funeral	1 X Never Married 2 Married	Was Decedent Ever in U.S Armed Forces? Yes 2 X No	If Yes	s, specify Cuba	n, Mexican, P	?(Specify Yes or No uerto Rican, etc.) Puerto Ric	White, e	
rs after ural",	<u> </u>	3 Vidowed 4 Divorced If Yes or Date 15. Decedent's Education (Specify only high	tes:				d of work done	16b. Kind of Busin	
72 hou al Exa	Completed		ollege (1-4 or 5+)	during mos	st of working life	e. DO NOT us	e retired)		
5-0036 led within 72 Hygiene. other than the Marial	립		5+ I	Directo	r of Nu	ırsing	Name (First, Middle,	Health C	are
21215-0036 wild be filled within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last)  Fermin Jose Sagardia	a				name (First, Middle, 1 Teresa V		
2121 ould be fi I Mental s marked ic event,	의	19a. Informant's Name/Relationship (Type, F				et and Numbe	er or Rural Route Nur	mber, City or Town,	
e, MD 1 and 2 sho Health and item 27 is		Edna T. Katz/ niece	Look Bl	45 Sou			Ave . Munde	lein, III	inois 60060
nore, MD 2 shou ages I and 2 shou mt of Health and N tr: If item 27 is nother traumatic		20a. Method of Disposition  1 Burial 2 X Cremation 3 Re	emoval from State	ematory or othe	er place)	•			
Baltimore, permit. Pages I ar Department of Her Important: If ite	-	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee		ro Crem			D8/U8/2012 Cremation So		re,Maryland
Bal permi Depa Impe		Diff Clife		299	Frede	cick Ro	oad Baltim	ore,Maryl	and 21228
Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each lin	ens that caused the death. E	Oo not enter the	e mode of dying	g, such as card	diac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	- 51	Immediate Cause (Final disease a. Hype	ertensive Atheroscle	rotic Cardio	vascular D	isease con	nplicated by fem	nur fracture	Death
The state of the s		Sequentially list conditions, b.	o (or as a consequence of):						
	iner	if any, leading to immediate Due t cause Enter Underlying Cause	o (or as a consequence of):						
=	Examine	(Disease or injury that initiated	o (or as a consequence of):						
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60, ate be ex physician	Medical		ENDED  c. If yes, outcome of pregna	ancy				23d. Date of de	livery
5876 ertificate ling phy		23b. Was decedent pregnant in the past 12 months?	Live birth		al death 3	Ectopic p	pregnancy	Month	Day Year
Box 68's death certificate a tree as a second of the attending	/sician/	1 Yes 2 V No 9 Unknown 9	Pregnant at time of death Unknown	5 Oth	er (Specify)				
O. Be at the de de de by the trached f	/ Phys	Part II. Other significant conditions cont	ributing to death but not res	sulting in the un	nderlying cause	given in Part	I. 23e. Did	-	ite to the cause of death?
s, P.O. nires that the signed by to doe detache	Completed by	Dementia					1 Ye		Probably 4 Unknown
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ital sician: is certi	8	25. Was case referred to medical examiner?	al: 1 Inpatient 2 E	ER/Outpatient		Othor	Nursing Home 5	Residence 6 🗸	Other: Scene
of Vital Records, ing Physician: The law requir After this certificate has been sumeral director, page 2 should	5	1 Yes 2 No 27. Manner of Death	28a, Date of Injury	28b. Time of In		jury at Work?		how injury occurred	
ion ttendir feath. tor: A	atio	1 Natural 5 Pending 2 ✔ Accident Investigation	Jul 14, 2012	2230 hrs	1	Yes 2 🗸 N			
Division of Vital Records, P.O. ral or strending Physician: The law requires that to safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor		t, factory, office	building, etc.	or Town.	State)	or Rural Route Number, City 43, Glen Arm, MD
Lospita Hospita 1 hours Tunera	O	4 Homicide	(Specify) Nursing Hor		ed at the time.	date and plac			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On	the basis of examination an manner stated.						
F. ½ F. 8	Me	29b. Signature and title of certifier				nse number			(Month, Day, Year)
		Mes			0.0	C.M.E.		August 8, 20	012
251		30. Name and address of person who comp Ana Rubio M.D., Ph. D. Ass	leted cause of death (Item 2 sistant Medical Exam		W. Baltimo	re Street. I	Baltimore, MD 2	1223	
	ate		32. Registrar' Signatu			4			·····
Regis		AUG I U ZUIZ LE	un 13. 19	-					

Patricia	Lynn	Triplett
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atticia Lyiiii 111		State Of Maryland / I- For State Registrar		ate of Dea			Reg. No.	2012 2551	
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)	A LYNN TR	RIPLETT		2. Date of De Month August 7	eath	3. Time of Death 2240 hrs	
		4a, Facility Name (if not institution, give street and number) 5323 Brookwood Road			, Town, or Location oklyn Park		4c. County Anne A		
Funeral Director		5. Social Security Number 213-62-8858 6. Sex 7. Age	(In yrs. last birti 59	hday) If Ur Mor Yrs.			17, 1953	y) 9. Birthplace (State or Foreign Country) Maryland	
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show any r traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10e. Street and Number  5323 Brookwood Road  11. Marital Status  1 Never Married  2 Married  12. Was Decedent E  Armed Forces?	Oc. City, Town	10f. Z				10d. Inside City Limits  1 Yes 2 X No hat Country?	
irs after d ural", or	à	3 Widowed 4 X Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade comp		1 Yes	2 X No specify	kind of work done	Specify:	White usiness/Industry	
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21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last)  Harry Dawson  19a. Informant's Name/Relationship (Type, Print )	19h	Mailing Addre		rs Name (First, Middle Mary Mason  nber or Rural Route N			
e, MD 2 I and 2 shou Health and In item 27 is n	٩	Ms. Kristi DiVenti (Daughter)  20a. Method of Disposition	20b. Place o	147 Olen	Drive, Gler	n Burnie, Mar	yland 210		
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other the		Burial 2 X Cremation 3 Removal from State     Donation 5 Other Specify:  21. Signature of Funeral Service Licensee Kevin E Ecl	Bayvie	ory or other place  W Cremate  22. Name ar	ory, Inc.	8/13/2012	_	re, Maryland	
Physician	-	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. <b>Oxycod</b>	MOO175	237 E	. Patapsco I	Ave., Baltimo	ore, Md. 21	225—1856	
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Intoxicati Due to (or as a conseq	on	.prazora	ш, пашост 1	gine and (	Jai isopio	Death	
ed nsit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Creat (or as a consequence of the consequence							
O, e be execut rsician and burial - tra	edical	M UNPENDED X AMENDED 4b, 2		8a-f,pe	r me,g931	9-10-12 s			
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be executed n. After this certificate has been signed by the attending physician and finneral director, page 2 should be detached for use as the burial - transit	Physician/M	IF FEMALE: (3b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown  23c. If yes, outcome 1  Live birth 4  Pregnant at tir 9  Unknown	2			c pregnancy	23d. Date of Month	delivery Day Year	
S, P.O. E uires that the d n signed by the	百	Part II. Other significant conditions contributing to death b	out not resulting	g in the underlyi	ng cause given in Pa	1 □ Y	es 2 No 3	ibute to the cause of death?  Probably 4  Unknown	
Division of Vital Records, rai or Attending Physician: The law requirers after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	Completed					per	opsy formed?	Were autopsy findings available prior to completion of cause of death?  Yes 2 No	
Vital Physician: this certified director,	To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ER/Ou	utpatient 3	26 Place of Death	(Check only one)  Nursing Home 5	Residence 6	✓ Other: Scene	
the the		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day,Yea	.2 fd	Time of Injury 10:39 pm	A	No unknow			
E 8 E	Certification:	4 Homicide determined (Specify) Fd	Reside	nce	ry, office building, e	Brook]	State) 5323 ] yn Park, l		
To the Hospital within 24 hours To the Funeral completely filled	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed								
L pend		30. Name and address of person who completed cause of dea	oth (Itam 22a)		O.C.M.E.		August 8,		
	ate	Ana Rubio M.D., Ph. D. Assistant Medica		900 W. B	altimore Street	, Baltimore, MD 2	21223		
Regist	rar	AUG 1 0 2012	WA.	fore					
OCME 2006	VV I	OCME	UR	IGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 per H G931 928/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 15:40 PM **Physician** 2012 Thom /Medical acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 113M 2□F 65 212-46-8839 Feb 22, 1947 Maryland Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location **Funeral Director** 1 Yes 2 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö death with "natural", or items 23a o 8406 Kavanaugh Road United States 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. þ If Yes, Give Year or Dates:√ e Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than aumatic event, the Me 12 Shuttle Bus Co. Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearce J. Thompson Dorothy McClure ည traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau Brenda Lynn Thompson /Wife 1311 Fuselage Avenue Middle River, MD 21220 Pages 1 8 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 07 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2012 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** pirator disease or condition resulting in death) /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami irrhos death certificate be executed burial-trar and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day page 2 should be detached for 4 Pregnant at time of death 9 Unknown 5 Other (specify) 2 □ No P.O. the 9 Unknown The law requires that the ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed peen a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA မှ this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending P after death. Director: After ti Certification: 1 Natural (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Homicide 24 hours Hospita 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the within 2 To the P 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 ar's Signature 31. Date filed (Month State 1 AUG 0 Registrar

DHMH 17 Rev 1/2001 11595 Mary VanKeuren

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		-	For State Registrar	_	State of	Marylar	nd / Depa <i>Cer</i>	artment <i>tificate</i>			and M	lental Hy	giene Reg. N	21	01	2 2	554
	Physicia Medic			e (First, Middle, Last n Keuren								2. Date of De Month	eath 02	<sup>ay</sup> 20	Year 12		of Death
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1072000	Funeral Director		5. Social Security Nu 150 18 14	umber 6. Se		'. Age (In yrs. 84	. Age (In yrs. last birthday)  84  Yrs.			If Under: Hours	Min.	8. Date of Bir (Month, Da Oct.25	ay, Year)	Year) Country)			or Foreign
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036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland ratment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at ea.	ed by Funeral	11. Marital Status	ied 2 🗆 Married	12. Was Deced Armed Ford 1  Yes If Yes, Give Year or Date	es? 2 X No	1		ent of His fy Cubar	spanic Orig n, Mexican	, Puerto I	cify Yes or No- Rican, etc.)		14. Race	- Americ , White,	an Indian, etc. ite	
Baltimore, Maryland 21215-0036	in 72 hour e. ian "natu Medical	Completed	(Spe	15. Decedent's Ed		1 or 5+)	(Give	lent's Usual kind of work O NOT use	done du retired)	uring most	t of worki	ng		Kind of Bus		dustry	
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£.;	Phy i i⊿n/ Medical		23a. Part 1. Enter t shock, or hear Immediate Cause ( disease or condition resulting in death)	rt failure. List only or Final		h line.	th. Do not enter									Approxim Interval B Onset and	etween
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90	ie be executed iysician and ne burial-transit		that initiated events resulting in death) I	S	c. Due to (o	r as a conseq	juence of):										
. Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be in 24 hours after death.  The Funeral Directors After this certificate has been signed by the attending physicis the Funeral Director. After this certificate has been signed by the attending physicis inpletely filled in by the funeral director, page 2 should be detached for use as the burnary.	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12, 1 ☐ Yes 2 9 ☐ Unknown	months?		irth 2 🗆 Fet ant at time of	al death 3	Ectopic pr		y				23d. Date Mon		ery Day	Year
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Division	ne Hospital or Attendir n 24 hours after death. Ie Funeral Director: Af oletely filled in by the fu	I Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place o	of Injury - At h g, etc. <i>(Specit</i>	ome, farm, str	eet, factory,	office			28f. Location ( City or To			r or Rura	l Route Nur	mber,
	To the Hospital or within 24 hours afte To the Funeral Director completely filled in	Medical	(Check 2	Certifying Phys	ner: On the basis	s of examination	on and/or inves	tigation, in m	ny opinio	n, death oc	ccurred at	the time, date	and plac	e, and due	to the ca	use(s) and r	manner stated.
	To the within 2 To the Comple	2	29b. Signature and		)		,	29c.	License	number	47	-	29d. D	ate signed	(Month,	Day, Year)	
	61		30. Name and addr	ress of person who c	ompleted cause	e of death (Iter	m 23a) (Type, I	Print)	T C A	-061		0. 0.0	F : A	70	(A) (D)	F) . 1 Cn	
	Sta Registr		31. Date filed (Mo	UG 10 20	12 3 Re	gistrar's Signa	m 23a) (Type, I	Mes	CSA	PIEM	ICK	المر الم	CCA	100	W- W	210	(
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Og 2012 4c. County of Death 0240 M KEGINALD LEONARDO AGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** LOCH RAVEN BALTIMORE 8. Date of Birth (Month, Day, Year) 11/08/1953 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours Min 1 M 2 □ F 217-56-5021 58 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "national many Injury or other transmissions." 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State Director 1 XYes 2 ☐ No Baltimore MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 4100 Carrison Boulevard USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 ☐ No If Yes, Give Year or Dates: 1973–77 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Lake Trout Elementary/Secondary (0-12) College (1-4or 5+) Kitchen Aide Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Woodrow Wilson Hessie Penn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4100 Garrison Blvd Baltimore, MD 21215 Ericka Wilson-Smith / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crownsville VA Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08.14.2012 Crownsville, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License Jan L. Williams Funeral Directors, P.A 4517 Park Heights Ave Baltimore, MD 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** CANCER disease or condition resulting in death) -UNG /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed thurs after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director.

Page 2 should be detached for use as the burst-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **√**0 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLC

D30272

3900 LOCH RAVEN BOULEVARD BACTIMORE, MD 21218

AUGUST 08, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 Physician/ Deandre Miracle Mohammed Bangurah 0130 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 7. Age (In yrs. last birthday) Hours Director 713-58-4786 1 **X** M 2 □ F July 8, 2012 Maryland 12 Usual Residence of Decedent 28a-f show 0a. State 10h County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director Beltsville Maryland Prince Georges 1X Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral United States 20705 4317 Josephine Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. o. ģ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) MONE Be event, rmit. Page 1 and 2 should be filed partment of Health and Mental Hyportant: If item 27 is marked out y injury or other traumatic eventy. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Abjatu Isata Sillah Ibrahim Ceceh Bangurah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4317 Josephine Avenue; Beltsville, Maryland 20705 <u>Abjatu Isata Sillah Bangurah</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July <sup>□ate</sup>7. XBurial 2 ☐ Cremation 3 ☐ Removal from State Department Important: It any injury or once. Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) 2012 Silver Spring, Maryland Marie and Address of Facility R.N. Horton Company Morticians, Inc.:600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician Due to (or as a consequence of): day disease or condition Medical resulting in death) **Examiner** 10 days Extreme prematurity Sequentially list conditions, it any, leading to in mediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Gram positive sepsis, Respiratory failure, patents ductus 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an alteriosus autopsy performed? Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 ★Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760

IJM

29a. Certifier

only one)

determined

Kimberly Ipfolla mo

Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar DHMH 17 Rev 06-2011

State

187016

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D50902

9901 medical Center Drive, Rockville, mD 20850

29d. Date signed (Month, Day, Year)

07 23 2012

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State State Registra AMEND #12 Per FH JM 7/279 artificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JTMCT 2<sup>D</sup>2 Physician/ 2012 6:25 Ам RICHARD LAWRENCE BROOKS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday **Funeral** Hours Days 577-38-0231 82 1 XM 2 □ F **Director** 8-6-1929 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 X Yes 2 No DISTRICT HEIGHTS PG MD 10e. Street and Numbe 10g. Citizen of What Country? 0 ber Funeral items 23a **IIS** 20747 6305 GATEWAY BLVD death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black White etc þ 1 Never Married 2 X Married "natural", or Yes Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes. Give Specify: BLACK Completed 3 Widowed 4 Divorced Year or Date 6 / 51 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Maone. than College (1-4 or 5+) Elementary/Secondary (0-12) FEDERAL GOVERNMENT SECURITY OFFICER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 MAGGIE MASON JACOB CHARLES BROOKS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GATEWAY BLVD, DISTRICT HEIGHTS, MD 20747 ANNA MCLAUGHLIN BROOKS/WIFE 6305 20b. Place of Disposition (Name of cemetery, crematory or other place, MARYLAND VETERANS 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 7-31-2012 CHELTENHAM, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service Licen 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 · MOLUS 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Ph\_sician/ resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 Yes 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Manner ath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia 7 In

1 Natural

Accident

3 Suicide 4 Homicide

29a. Certifier

(Check

31. Date filed (M

only one

3 🗆

29b. Signature and title of certifier

5 Pending

Investigation 6 Could not be

determined

Konn

State Registrar

Medical

injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRATTS ROAD,

Tronnu

32. Registrar's Signature

work?
1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

SUDHEER SANIKOMMU, M.D.

D69737

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

3

CLINTON, MD 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b, per fh, g930 8-10-12 sm State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 7 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 322 M 2012 Myrtle June Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HILIMICO Medical SALISBUL TENINSULA If Under 1 Year If Under 24 Mrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year) Director 218-12-5721 1 □ M 2 🗓 F 90 WV 6/2/1922 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentai Hygene.
If health and Mentai Hygene.
If marked other than "natural", or items 23a or 28a-f show of the traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1X☐ Yes 2 ☐ No Keyser Mineral 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral 26726 164 A Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White Completed 3 x Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Sr. Thomas Nash, Estelle Emmart 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trausonce. MDWalston Switch Rd., Salisbury, Jennifer Manzione/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Donation 5 ☐ Other (Specify) 8/10/12 Keyser, Potomac Mem. Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Markwood Funeral Home, Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 hours disease or condition resulting in death) Medical RENAL FAILURE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). 72 hours the attending physician and shed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached formation. a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ISCHEMIC CARDIOMYOPATHY 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 WER/Outpatient 3 ☐ DOA ဥ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending м 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Sertifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 20 30. Name and address of person who completed cause of deat (Item 23a) (Type, Print) 21804 DRIVE SAUBURY EMMANUEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

1 0 2012

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ™ANug 3, **2**1012 Melvin **Brehm** 9:10 AM<sub>M</sub> Eugene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Cumberland 418 E. Oldtown Road Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. 1 🔀 M 2 🗆 F 212-38-7437 Mar 9: 4937 75 **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Coun 10c. City, Town or Location

Cumberland 10d. Inside City Limits Director Allegany MD 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 418 E. Oldtown Road 21502 USA 12. Was Decedent Ever in U.S. Armed Forces ↑ 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
 □ Yes 2 □ No Specify: 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sewer Dept. City of Cumberland Be 18. Mother's Name (First, Middle, Maiden Surname)

Josephine Lisanti 17. Father's Name (First, Middle, Last) မ Melvin Brehm 19a. Informant's Name/Relationship (Type, Print) Judy Brehm Mailing Address (Street and Number or Rusal Route Number, City or Town, State, Zip Care) 21502 wife 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. Mary's Cemetery 8/7/2012 MD Cumberland 4 Donation 5 Other (Specify) ignature of Funeral 9 ervic 22. Name ar Scarpellif Furiteral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ Myrcoden disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a cor Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Feτai uea ☐ Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ğ 1 Fyes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? After this certificate 2 🗌 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\overline{ ပ္ 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 - Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No Accident
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

 Hospital or Attending Physician: The law requires that the death certificate be s.
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 completed filled in by the funeral director. within 2 To the F

Baltimore, Maryland 21215-0036

State

Medical

29a. Certifier

(Check

only one 29b. Signature and title of cert

J130 /1100 170

00017565

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

The deficial Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) august 7. 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

MD 21502 LaVale. 910

31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 0 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1.35PM Evelyn G. Culler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fahrney-Keedy Nursing Facility Washington <u>Boonsboro</u> Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Months Director 217-24-7446 1 M 2X F 85 Sept.3, 1926 Maryland 28a-f show 10b. Count 10d. Inside City Limits 10c. City, Town or Location event, the Medical Examiner must be notified at Director Maryland Frederick Frederick 1 X Yes 2 □ No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 814 Montclaire Ave. 21701 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married o ò Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) +2<u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ Lewis E. Green Carrie Idella Cashman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. 817 Montclaire Ave., Frederick, MD 21701 Patricia Wiser / Daughter Baltimore, Method of Disposition
1 

Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Luke's Cemetery 7/28/2012\_ Feagaville, Maryland Signature of Funeral Service Lice 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick. Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed -tran Due to (or as a consequence of): resulting in death) Last burial-Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 month ρģ Month Day Pregnant at time of death Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 2 2 Division of Vital 25. Was case referred to 26. Place of Death (Check only one) Be Hospita 2 No 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA ome 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of ë 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours aff

To the Funeral Di

completely filled in ca 29a. Certifier 1💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 0 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

(TT

State Registrar Melo

Vincent Cantone,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Redistrar's Signature

D0050362

13424 Pennsylvania Ave., Hagerstown, MD 21740

July 25, 2012

12-05621

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Christina Church Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 28, 2012 Church 0112 hrs Christina Eleni 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1/13/1986 Hours Davs 2.6 215-53-6815 Country) Director 2<sup>X</sup> F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Gaithersburg Montgomery hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20878 USA 15345 Falconbridge Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces? 1 Never Married 2 Married 2 X No 1 Yes White 5 1 Yes 2 X No specify: Specify 4 Divorced If Yes. Give Year δ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 linent of Health and Mental Hygiene.

ant: If item 27 is marked other than "a or other traumatic event, the Medical E. Retail Sales Manager Ice Cream Co. Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Carol Mae Crane Stephen Michael Church Be 19a. Informant's Name/Relationship (Type, Print ) father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5747 Potomac Avenue NW Washington, 1616 Stephen Michael Church/ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 8/1/2012 Rockville, Md Parklawn Memorial Department o 4 Donation 5 Other Specify. <u>ቅሰግኒግ ውዕሙን የተ</u>ለልLDI FUNERAL SERVICE, PA 9241 Columbia Blvd.Silver Spring, Md2091 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Oxycodone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED 23a, 27, 28a-f, per me, g930 8-14-12 sm X UNPENDED the attending physician ed for use as the burial -23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 3b. Was decedent pregnant in the Year 1 Live birth 3 Ectopic pregnancy 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed l <u>چ</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed 24h Were autopsy findings available 24a Was an this certificate has been a director, page 2 should prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 🗸 Inpatient 2 Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA 2 No 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 27. Manner of Death Certification: To the Funeral Director: A To the Funeral Director: A 'To the Funeral Director: A' 1 Natural 1 Yes 2 X No unknown fd 7-27-12 fd 2:00 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Suburban Hospital** 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide bathroom of hospital room Bethesda, MD. determined 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 28, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore. Street, Baltimore, MD 21223 Ling Li, MD 32 Registrar's Signatu State 6 2012 Registra

		1 - For AMEND#16 aperMFH, 8/6 712; Prof., Maryland State Registra MEND#3 perMD, 6/8/12: EWW, McCo	/ Depa	irtment of H tificate of D	lealth and M <i>leath</i>		jiene Reg. No. 2	010	0 00000		
Physic	ian/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		∑ear	3. Time of Death		
	dical			4b. City, Town, or	Location of Death	oury_	4c. County		I W		
- P		12020 Judson Road	hirthday)	Silver If Under 1 Year	Spring	8. Date of Birth		ntgor	nery place (State or Foreign		
Funera Directo		160-18-2455   1 <sup>™</sup> M 2□F   94	Yrs.	Months Days	Hours Min.	1 2 1 2 6 4	Ť° <b>9</b> ′1 7		rginia		
land show dat	٦	Usual Residence of Decedent  10a. State 10b. County MD Montgomery Si	own or Loc	ation Spring					10d. Inside City Limits		
ne Mary or 28a-f notifie	Direc	MD Montgomery Si		10f. Zip Code			10g. Citizen of	What Cour	1  Yes 2 No		
h with the	Funeral Director	12020 Judson Road		209	02			JSA	,.		
ING 21215-0036  filed within 72 hours after death with the Maryland tal Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	۾ ا	1 Never Married 2 Married 1 Yes 2 No 194	2	/as Decedent of His Yes, specify Cubar ☐ Yes 2 ★No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ck, White,	can Indian, etc. nite		
15-C 72 hou n "natu Aedical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)	(Give k	ent's Usual Occupa ind of work done d NOT use retired)	ation Butch uring most of worki	er	16b. Kind of B	usiness In	dustry		
212 I within ygiene. her tha t, the N			Store								
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	To Be	17. Father's Name (First, Middle, Last) Dacob Tunstal Chaney			18. Mother's Name Bertha			e)			
Mary 2 should Ith and N 27 is ma		1		g Address (Street a			-				
			e of Dispos	Box 70	, [	Date	20c. Location				
Baltimore, permit. Page 1 and Department of Hee Important: If item any injury or othe		4 □ Donation 5 □ Other (Specify) Che	sape	eake Cre	m. 7/25		Belts				
Balti permit. Departi Imports any inji	010	21. Signature of Funeral Service Lights e	PH 92	Maria Adams 141 Colu	R'IN'ALDI mbia Bl	FUNER vd.Sil	AL SEE ver Sp	RVICI orino	E,P.A. g,Md20910		
		23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.				or respiratory arre	est,		Approximate Interval Between Onset and Death		
Ph siciar Medica Examine	al	Immediate Cause (Final disease or condition resulting in death)  Congestiv  Due to (or as a consequence)		art rar	rure			- 1	- 11		
LAGIMIN	8.	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying									
and	Examiner	Cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  C.  Due to (or as a consequence)	ce of:								
60 ate be exe ohysician a	edical E	d									
ob/c	/Med	IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome of pregnancy					1				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burgil-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. Nest, outcome of pregnant 2 to 1 location of pregnant 2 lo	eath 3 🗌	Ectopic pregnancy Other (specify)	4			ate of deliv	ery Day Year		
'dS, P.O.  equires that the sen signed by to ould be detach	ted by P	Part II. Other significant conditions contributing to death but not result	ng in the ur	nderlying cause give	en in Part I.				he cause of death? bably 4 □ Unknown		
VITAI KECOTGS,  sysician: The law requires is certificate has been sig director, page 2 should b	Completed					24a. Was a autops perfor 1 Yes	sy med?		psy findings available impletion of cause of		
VITA vysician vysician is certif	To Be	examiner?	VOutpatient	Othe	r: 4  Nursing Ho		ence 6 🗌 Oth	er (Specify	()		
of of of of oding Ph. th. After the funeral	cate:		b. Time of injury	28c. Injury work? M 1 🗆	at ? Yes 2 □ No	28d. Describe ho	w injury occurr	red			
DIVISION OF tal or Attending Ph rs after death. al Director: After th ed in by the funeral	al Certifi	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State)									
ie Hospi n 24 hou ie Funer oleted fill	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge only one)  3 Certifying Nurse Practioner: To the best of my knowledge only one)	nd/or investi	gation, in my opinio	n, death occurred at	the time, date an	id place, and du	e to the ca	use(s) and manner stated.		
withi of the party of the party		29b. Signature and title of certifier  European Signature and title of certifier		29c. License	number	7	9d. Date signe Jυ		Day, Year) 25,2012		
		30. Name and address of person who completed cause of death (Item 23  Evelyn Jackson MD	3416	Olandw	ood Com	rt #200	) Olne	v . Mc	20832		
Si Regis	tate trar	31. Date filed (Month, Day, Year)  JUL 26 2012  31. Registrar's Signat fre	pa	N.S.				, , , , ,			

			State of Maryland / Department of Health and	Mental Hy	giene	1.0	05551
			Registrar Certificate of Death		Reg. No.	12	25551
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Mae Bell Covington—Wright	2. Date of De Month <b>July</b>	22, 20		3. Time of Death <b>5:15 P.</b> M
•	Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deat		4c. County o		
1			3701 - 64th Avenue Cheverly		Prin	ce Ge	orges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir	th ly, Year)1937	9. Birthpla Country	ce (State or Foreign
	Director		24/-62-2368 1 □ M 2 🕅 F   74 Yrs.	Decembe		-	Carolina
	d t ow	_	Usual Residence of Decedent  10a. State 10b. County 10c, City, Town or Location	ресешье	1 11,		. Inside City Limits
	rylan ied a	cto	Maryland Prince Georges Cheverly			100	1 X Yes 2 No
	e Ma r 28a notif	Oire	10e. Street and Number 10f. Zip Code	1	10g. Citizen of Wi		
	ith th	Funeral Director	3701 – 64th Avenue 20785		United	-	1
	ath w	au	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	necify Yes or No-		- American	
0	or ite	by F	1 Never Married 2 Married 1 Yes 2 No	to Rican, etc.)		, White, etc	
e e	safte ral", Exar	be l	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 🛣 No Specify: Year or Dates.		Specify:	Blac	:k
0	hour natu iical	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo	4.5	16b. Kind of Bus		
21	in 72 e. nan "	Ĕ.	Elementary/Secondary (0-12) College (1-4 or 5+) life. DO NOT use retired)	rkirig	District		
2	l with /gien her ti t, the		6 years plus   High School Teacher		Public Public	Schoo	1s
<u>n</u>	1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. it he ath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	To Be			Maiden Surname)		
<u>₹</u>	uld be Men narke natic	-	Elijah Kelly, Sr. Alice	Simo	'II		
۸ar	should and Me is mar raumati		19a. Informant's Name/Relationship (Type, Print) Raefield Wright (Husband) &	ural Route Numbe	r, City or Town, Sta	ate, Zip Coo	<sup>fe)</sup> 07083
<u>د</u> ک	and 2 Health em 27 ther tr		Dr. Melva Trinetta Covington(Daughter)10/0 Morris Ave				
ore	le 1a tof H If ite or otl	- 1	20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery-crematory or other place)  Jul	y 30,201	20c. Location - 0	City or Town	n, State
Ē	. Page tment o tant: If jury or		4 Donation 5 Other (Specify) Fort Lincoln Cemetery		Brentwo	-	
Baltimore, Maryland 21215-0036	permit, Page 1 a Department of I Important: If it any injury or of		21 Signature of Funeral Service license 22. Name and Address of Facility ${f R}_{ullet}$		_	-	
	<u> </u>	_	MO1421 Inc.; 600 Kennedy S			ngton	,D.C.20011
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	c or respiratory ar	rest,	lr.	pproximate Iterval Between
F	hysician/	9 6	Immediate Cause (Final disease or condition Malignant Neoplasm of the Stomach	1		C	nset and Death
Ť	Medical Examiner		resulting in death)  Due to (or as a consequence of):				
	Ladillilei	<u>_</u>	Sequentially list conditions, b.				
	n #	nine	if any, leading to immediate Due to (or as a consequence of):				
	executed an and rial-transi	Examiner	Cause (Disease or Injury that initiated events c.				
	be exe sician a burial	aE	resulting in death) Last  Due to (or as a consequence of):				
<u></u>	te by	dical	d				
200	certifica nding pl use as t	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
	ath ce	ian	in the past 12 months?		23d. Date Mont	of delivery th D	
ň	the shed	ysic	1 Pres 2 No 4 Pregnant at time of death 5 Other (specify)				
л Э	nat th ed by detac	린	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contrib	oute to the	cause of death?
,	requires that the death been signed by the atte should be detached for	d by		1 🗆	Yes 2 No :	3 🗌 Probal	oly 4 🗶 Unknown
ğ	requ	ete		24a. Was			findings available
ည် မ	has b	Completed		auto	psy pr		letion of cause of
ř	r: The ficate or, pa	-	25. Was case referred to medical 26. Place of Death (Che		ormed? de 2 <b>X</b> No 1	☐ Yes 2	□ No
ita	sictal certii irecto	Be c	examiner? Hospital:				
<u>&gt;</u>	Phy:	£ 10	27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at		dence 6  Other		
ב	ding th. Afte fune	cate	1 Matural 5 ☐ Pending (Month, Day, Year) injury work? 2 ☐ Accident Investigation M 1 ☐ Yes 2 ☐ No	ZBG. ZBGGIIZG	ion injury occurred	-	
Division of Vital Records,	Atter r dea ctor: by the	ertificate;	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (	Street and Number	or Rural Ro	oute Number,
Ξ.	after Dire	O	building, etc. (Specify)	City or Tov			
_	spita hours neral y fille	ical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,				
	to the hospital or Aftending Physician: The law within 24 hours after death.  To the Funeral barector. After this certificate has completely filled in by the funeral director, page 2:	Medical	(Check only one)  Quadratic (Check only one)				
	withi To th	-	29b. Signature and title of pertifier 29c. License number		29d. Date signed		
			ANP-BC AC000937		Ju1y	25,	2012
	15m		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9200 Basil Co		te 200		
			Melanie Reynolds; CNP Largo, Maryla	-			
	Stat		31. Date filed (Month, Day, Year) /32. Registrar's Signature				
	Registra	ır	JUL 2 02012 Jenna B. Joanel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Christaimas Carroll 2012 25552 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day July 27, 2012 Christaimas Carrie Carson Carroll " dical Examiner 1259 hrs 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 9. Birthplace (State or 7. Age (In yrs, last birthday) **Funeral** Months Davs Hours Min Director CountryVirginia 577-70-7858 2 X F 60 Yrs November 25. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No District of Columbia 28a-f show Washington Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho rector s 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1418 Downing Street, N.E.; Apt. 1 20018 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 3 X Widowed 4 Divorced If Yes Give Yeer Yes 2 X No specify: Specify: Black Examiner **≙** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical timore, MD 21215-0036 Catholic University 12th grade Cook 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Simon Ned Margaret Marie Washington 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or nther traumatie Christine Doriann Carroll 3902 - 26th Avenue; Temple Hills, Maryland 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) Aug.8, 1 X Burial 2 Cremation 3 Removal from State rtment c Fort Lincoln Cemetery 2012 Brentwood, Maryland Donation 5 Other Specify permit. Departm 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea 23a, Part I, Enter the disease, or complication **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Hypertensive Cardiovasular Disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED 23a, pt. II, 27, per me, g932 10-17-12 sm attending physician Box 68760, IF FEMALE: 23c, if yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be be deta ₫ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? certificate ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) **Division of Vital** Be examiner? Other<sub>4</sub> Hospital: Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: this 1 Yes 28a. Date of Injury (Month. Dey, Year) After 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural Director: 5 Pending 1 Yes 2 No death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 28, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State

Registra

arks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29 2012 July 7:58 A M Lloyd Harvey Crampton Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 3823 Harpers Ferry Rd. Sharpsburg Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 212-24-5254 Director 1**XX**M 2 ☐ F Jan.3,1929 Yrs Maryland 83 Usual Residence of Decede er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Sharpsburg 1 Yes 2X No Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21782 USA 3823 Harpers Ferry Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2XXNo
If Yes, Give by Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 f n and Mental Hygiene. 7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jamison Margaret Mae Lloyd Cecil Crampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3823 Harpers Ferry Rd. Sharpsburg, Maryland 21782 Reva Crampton - Wife 27 Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XXBurial 2 Cremation 3 Removal from State View Cemetery Aug.2,2012 Sharpsburg, Maryland 4 Donation 5 Other (Specify) of Funeral Service Micensee 22. Name and Address of Facility Osborne Funeral Home, P.A. Signature 425 S. Conococheague St.Williamsport, MD 21795 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ephros chos disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 ding phy for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 2 X No Yes 2 N the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation Could not be filled in by the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D28365 Man Jan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 368

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month а м 30 2012 9:24 <u>Catherine Irene CLINE</u> July Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9710 Old National Pike Washington Hagerstown Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Month, Day an. 29 1 🗆 M 2 💢 F Months Days Hours Mary land Director 89 Jan. โ′923 216-14-5159 Usual Residence of Decedent show 10a. State 10b. County death with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Maryland Washington Hagerstown 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21740 USA 9710 Old National Pike items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No , or Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Completed by 1 Yes a Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Harlan Rider Lula Gruber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Cline - Son 1909 Maplewood Circle, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State Department of Important: If any Injury or 4 Donation 5 Other (Specify) Rest Haven Cemetery 8/8/2012 Hagerstown, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 Ε. Hagerstown, Maryland 21740 Wilson Blvd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury burial-transi that initiated events resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the 38 IF FEMALE nse s yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day signed by the a 2-No 1 L Yes 2+ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate 2 No 1 Yes Yes Be 25. Was case referred to vedical 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 \(\sime\) Yes 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie completed Chec 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nly øne) 29b. Signature and title of certifier

Registrar

State

30. Name and address of person



Bradley Joseph		1- For State	State	of Maryla		artment ertificate			d Menta	al Hy			0.0	10 0555
Physicia	_	Registrar  1. Decedent's Name (First	t, Middie,La	st)						2	2. Date of Dea		40	3. Time of Death
Medical Exami	ner	Bradley Jos									Month July 26, 2		/ear	1835 hrs
<b>,</b> )		4a. Facility Name (if not in Route 66 & Pace		ve street and nu	mber)		1	, Town, or I Aetna	Location of	Death		4c. Coun Wash	ty of Deat	h
Funeral		5. Social Security Number		Sex	7. Age (In yrs	. last birthday)		nder 1 Year	If Under	24Hrs.	8. Date of Bi		YYY 9. Bir	rthplace (State or
Director		397-92-0580		Дм 2□ F	28	Υ	rs. Mon	ths Days	Hours	Min.	Dec.	9, 198.	Forei	gn Wisconsin
		Usual Residence of Dece	dent							!		J, 230.		
w any			county ankli	n		y, Town or Loc ynesbor								10d. Inside City Limits  1 XYes 2 No
yland t-f sho	į	10e. Street and Number	aikli	.11	wa	ynesbor		ip Code			1	l0g. Citizen of	Mhat Cou	
ith the Maryland 23s or 28s-f show notified at once.	Director	324 Ridge	Dag					7268			- 1			ind y r
with th		11. Marital Status			edent Ever in		Vas Dece	dent of His			cify Yes or No	U.S.A - 14. Ra		ican Indian, Black,
death or iten	Funeral	1 Never Married 2	Marrie	d Armed Fo	orces?				, Mexican, I	Puerto R	tican, etc.)	l w	nite, etc.	
s after	ğ		_	d If Yes, Give Yea or Dates:				2 X No				Specif		ite
2 hour	eted	15. Decedent's Education  Elementary/Secondary		College (1		16a. Deced during			DO NOT u			16b. Kind of	Business/	Industry
336 thin 7, se.	ם	12	(5 .=/		,,	Insta	llat	ion T	ech.			Secur	ity	Co.
215-0036 be filed within 7 tral Hygiene. rked other than ent, the Medica	$\sim$	17. Father's Name (First,		•	<del></del> _			- 1		-		Maiden Surnar	ne)	
2121 ould be fi Mental marked c event,	Be	Roger Chri				I 10h Mail	in a Adden				elpflug	mber, City or T	0	7:0-1-)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	은	Linda Christ												s, WI 53051
e, N I and 2 Health item 2	ŀ	20a. Method of Dispositio				. Place of Disp	osition (N	ame of cerr			Date			Town, State
Baltimore, Permit. Pages I an Department of Hee Important: If ite		1 Burial 2 Cro			om State	crematory or mithsbu			orv	7-31	1-2012	Smith	shur	→ MD
altir mit partm	ı	21. Signature of Funeral S			0	22	Name an	nd Address	of Facility	Doug	las A	Fiery	Fun	eral Home
	-	Kaitting	alla	rous	uto	1	.331	Easte	rn BL	.vd.	North	Hagers	town	, MD 21/42_
Physician Medical		23a. Part I. Enter the dise failure. List only one	cause on e	ach line.		in, Do not ente	r the mode	e or ayıng, s	such as car	alac or r	espiratory arr	est, snock, or	neart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final or condition resulting in d		Multiple Inju		of):								
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50, te be ex tysician	- 00 ⊢	IF FEMALE:	L		outcome of pre	anancy						23d. Date	of deliver	
Box 68760, e death certificate by the attending physic ed for use as the bur		23b. Was decedent pregna past 12 months?	ant in the	1 Live b	irth	2 🔲 1	etal deat	h 3	Ectopic p	oregnand	Э	Month		Day Year
eath ce atten for use	sici	1 Yes 2 No 9	Unknow		ant at time of o	death 5	Other (Sp	ecify)				10		
o.O. Be that the de ned by the detached for		Part II. Other significant	conditions			resulting in the	underlyir	ng cause gi	iven in Part	l.	23e. Did to	obacco use co	ntribute to	the cause of death?
ires that the signed by the detache	d by										1 Yes	2 🗸 No	3 Prol	bably 4 Unknown
ords, w requir	olete										24a. Was autop	sy		topsy findings available completion of cause of
Reco The law cate has	Completed										perfo 1 <b>Y</b> Yes	rmed? 2 No	death? 1 ✓ Ye	es 2 No
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death.  Tai Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacol	Be	25. Was case referred to examiner?		Hospital:		7		1/	of Death (C					
of Vil ing Physic After this	P.	1 ✓ Yes 2 1		28a. Date	npatient 2	ER/Outpatie			y at Work?			Residence 6		r: Scene
ion of tending Pheath.	ţį	1 Natural 5	Pending	Jul 26, 2	Day Year) 012	1817 hrs			es 2 🗸 N	ls.		er in auto a		lision
ivisior  I or Attendather death  Director: d in by the	Certification:	2 Accident 3 Suicide 6	Investigat Could not	28e Place	of Injury - At	home, farm, str	eet, factor	ry, office bu	uilding, etc.	2			nber or Ru	ıral Route Number, City
Di: Hospital (24 hours a Funeral I	S	4 Homicide	determine	d (Specify)	Major Roa	ad / Highwa	ıy			R	or Town, S oute 66 & P	acer Drive, N	It. Aetria	, MD
8 4 E S	dical	29a. Certifier (Check only one) Certifier Medic	ying Physic	lan: To the bes	t of my knowle	dge, death occ and/or investig	urred at thation, in n	ne time, dat	te and place death occu	e, and di arred at t	ue to the caus he time, date	e(s) and manr and place, and	ner as stat	ed. e cause(s)
To the within To the complet	<b>a</b> b ∟	29b. Signature and title of		and manner st	ated.			9c. License						nth, Day, Year)
		111	1	1/ M	D			O.C.N	1.E.			July 27, 2		
	}	30. Name and address of	person who	completed caus	e of death (Ite	m 23a)						1		
144 - MI		Melissa Brassell		ssistant Me			W. Balti	imore St	reet, Bal	timore	, MD 2122	23		
Sta	ate	31. Date filed (Month)	Year)	32. Re	istrar's Signa	ture	San Ma	1				_		

				Type or Prin								gible.	
		4	For AMEND 2 per PHY State 7/25/2012 AACO	State of Ma	aryland / CMH	Departme	nt of F	lealth a	and M	1ental Hy	giene		
			Registrar  1. Decedent's Name (First, Middle, La.			Certifica	te or L	<i>Jeatn</i>		2. Date of De	Reg. No.	$n_2$	2 5 5 5 6 3. Time of Death
	Physicia Medic	n/	SHIRLEY P	_	ММА	550				Month	Day	Year 2012	10:22a M
	Examin		4a. Facility Name (if not institution, give 917 Dantrey Cour	e street and number)				Location of			4c. Coun	ty of Death	
-	Funeral		5. Social Security Number 6. S		e (In yrs. last bir	thday) If Und Month	ler 1 Year s Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi			hplace (State or Foreign intry)
	Director		215-40-6460 Usual Residence of Decedent	I □ M 2 🔀 F	69	Yrs.	Suyo	l nours	1011().	Mar. 2		3	Virginia
	land show	to	10a. State 10b. County		10c. City, Tow								10d. Inside City Limits
	Mary 28a-1	Jirec	MD		ватт	imore							1 X Yes 2 ☐ No
	ith the	Funeral Director	10e. Street and Number 917 Dantrey Cour	ct		10f. 2	Zip Code	21225			10g. Citizen o	f What Cou US	
	eath w	une	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Dec			in? (Spe	cify Yes or No Rican, etc.)	14. Ra		ican Indian,
36	after d ", or i	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀	No			n, Mexican, Specify:	Puerto	Rican, etc.)	Bl Speci	ack, White	, etc. Mite
00-	nours a	Completed by	3 ☐ Widowed 4 😾 Divorced  15. Decedent's E	Year or Dates.	16	a. Decedent's Us	0.43	-63			16b. Kind of	·y.	
215	in 72 h e. nan "r	duc	(Specify only highest gi Elementary/Secondary (0-12)	rade completed) College (1-4 or 5		(Give kind of v life. DO NOT u	rork done c	during most	of worki	ng	TOD. KING OF	Dusiness/1	ridustry
7	dygien Hygien ther ti	a h	17. Father's Name (First, Middle, Last)		<u> </u>		Iomem					Hor	me
lanc	be file ental } 'ked o ic eve	일	John Henry Dotso								, Maiden Surnai Auline N		r
Maryland 21215-0036	should and M Is mar		19a. Informant's Name/Relationship (			b. Mailing Addre							
	and 2 s lealth sm 27 her tra		Denise Rodriguez	z/Niece		5220 Sta		Court	Fo	rt Belv	· ·		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐		cemete	of Disposition (Nery, crematory o	r other plac		July	23,	20c. Location	-	
altir	mit. Parame sortan v injury	H	4 ☐ Donation 5 ☐ Other (Special 21. Signature of Fundral Service Liver		j Me	tro Cre		y ss of Facility Direc	<u>20</u>	12	Balti	more	, UD
<u>m</u>	permit Depar Impor any in	9. 3	O Ames C	of Las	mci	495	Ritch	ie Hwy	7.	Seve	ma Park	, MD	21146
			23a art 1. Ent of the disease, or comshock, or leart failure. List only	n cause on each line	the death. Do	not enter the m	ode of dyin	g, such as c	eardiac d	r respiratory a	rrest,		Approximate Interval Between
Z	Pnysician/ Medical	1	Immediate C use (Final disease or of ndition resulting in death)	a. Coron	cons-nuence	Actery	Di	seas	e			-1	Onset and Death
	Examiner	4		Diob	e45	Mellit	us						
	sit d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin	Due to (or as a	consequence	of):							
	executed an and rial-transi	Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence			^ ^					
0		Completed by Physician/Medical	· ·	od. Chron	iic R	enal	Insi	Africa	cie	nay			
Box 68760	rtificat ling ph	/Mec	IF FEMALE:	00- 16				• 1					
) XO	attend attend	cian	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	23c. If yes, outcome of Live Birth 4 Pregnant at	2 Fetal dea	th 3 Ectopi		у				Date of deli Month	ivery Day Year
Э.В	the deby the tached	hys	9 ∐ U <b>n</b> known	9 🗌 Unknown									
, P.O.	es that igned be de	by	Part II. Other significant conditions	contributing to death be	ut not resulting	in the underlyin	g cause giv	ven in Part I.	•				the cause of death?
ords	requir been s should	letec	10(1) [700.	AIVC 10	LOJVET C	) 1000	.01			24a. Was		`	obably 4 Unknown
3ecc	he law te has	ошо								auto perf	opsy ormed?	prior to c death?	completion of cause of
la F	ian: T ertifica etor, p	Be C	25. Was case referred to medical examiner?				26. PI	ace of Deatl	h <i>(Check</i>		2. No	⊺ ⊔ Yes	2 L No
Ť.	Physic this ce	유	1 ☐ Yes 2. No 27. Manner of Death	Hospital:  1  Inpatie		utpatient 3  Time of		4 ⊔ Nui	-		idence 6 🗆 O		fy)
0 0	tth. : After e funel	cate	1. Natural 5 Pending 2 Accident Investigation	(Month, Day	, Year)	injury M	28c. Injur work		- 1	28d. Describe	how injury occu	rred	
Division of Vital Records,	r Atter ter des ractor ractor	ertif	3 Suicide 6 Could not 4 Homicide determined	be 200 Place of Injur		arm, street, fact	ory, office		$\neg$	28f. Location		ber or Run	al Route Number,
Ö	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Diractor: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical Certificate:	OG- O-ME PL	1		t et			. 4				
	e Hos 124 hc e Fun	<b>Jedi</b>	(Check 2 <u></u> Medical Exam	ysician: To the best of niner: On the basis of ex rse Practitioner: To the	xamination and/	or investigation,	in my opinio	on, death occ	curred at	the time, date	and place, and o	lue to the c	ause(s) and manner stated.
	To the To the comp	_	29b. Signature and title of certifier	1	,		9c. Licens				29d. Date sign		1
			CUS		~	MD	De	563	25	5	7/	23	2012
(	41		30. Name and address of person who	completed cause of de	_ '	(Type, Print)	HERF	2V H	11.7	RD	BAL	r Ma	RE 1/10 2122
	Sta Registr		31. Date filed (Month, Day Year)	2012 32. Registra	ar's Signature	A de		~/ [1	*	. 105		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	C, NU LKS

			For State	State of Maryland	-				21	112 2555	7	
			1 - State Registrar  1. Decedent's Name (First, Middle, Last)  Provider Lamps Dimler  2. Date of Death  Month  Day  1. Desember 1 - Desember 1 - Desember 2 - Des						3. Time of Death	1 1		
П	Physicia Medic		Brendan James Din	ler					8, 2012	Year 7:00 A	VI	
		Examiner  4a. Facility Name (if not institution, give street and number)  Genesis Fairland Nursing Home  4b. City, Town, or Location of Death  Silver Spring							4c. County	of Death tgomery		
	Funeral		5. Social Security Number 6. Sex		t birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt	h	Birthplace (State or Fore)		
ш	Director		215-94-7114 Usual Residence of Decedent	\$M2□F 43	Yrs.	Working Bayo	710010		9,1968	Cheverly, Marylan	ıd	
	/land f show d at	tor	10a. State 10b. County		Town or Loc	ation				10d. Inside City Limit		
	r 28a- notifie	Direc	Maryland Prince G	George's E	Bowie	10f. Zip Code			10g. Citizen of V	1 K Yes 2 \( \text{Nhat Country?} \)	10	
	with the s 23a c ust be	Funeral Director	1307 Yorktown Dri	ve			715		US.			
21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status  1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 👿 No	n, Mexican, Puer	pecify Yes or No- to Rican, etc.)		e - American Indian, ck, White, etc. White		
15-0	72 hou "natu edical	Completed	15. Decedent's Edi (Specify only highest grad		(Give k	ent's Usual Occupa ind of work done d		rking		usiness/Industry		
212	iled within 72 Il Hygiene. I <b>other than</b> ' vent, the Me		Elementary/Secondary (0-12)	College (1-4 or 5+)		NOT use retired) rity / Pai	rking At	tendant	CSC /	Redskins		
73	d be filed Aental Hy Irked oth tic event	To Be	17. Father's Name (First, Middle, Last) Edward Dimler				18. Mother's Na	me (First, Middle, B <b>ird</b>	Maiden Surname	e) 		
	Page 1 and 2 should be file nent of Health and Mental k ant: If item 27 is marked o iny or other traumatic eve		19a. Informant's Name/Relationship ( <i>Typ</i> Edward J. Dimler		19b. Mailin 3531	g Address (Street a 56th Str	eet, Hya	ural Route Numbe	r, City or Town, S	State, Zip Code) 784		
Baltimore,			20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗆 I  4 🗆 Donation 5 🗀 Other (Specify)	Removal from State cen	netery, crem	sition (Name of patory or other place In <b>Cemeter</b>		Date 5/2012		City or Town, State od, Maryland		
Balt	permit. Page 1 a Department of I Important: If its any injury or of once.		21. Signature of Funeral Service License	e Negars		Name and Addres	-	ome, P.A.	4739 B Hyatts	altimore Avenuville, MD 2078	је 31	
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	e cause on each line.			g, such as cardia	c or respiratory an	rest,	Approximate Interval Between Onset and Death		
	Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Cardiopulmonary Arrest  Due to (or as a consequence of):									
		L	Pneumonia									
		mine	if any, leading to immediate Lause. Enter Underlying Cause (Disease or injury) Cause (Disease or injury) Cause (Disease or injury) Cause (Disease or injury)									
	be executed sician and burial-transit	edical Examiner	that initiated events resulting in death) Last	Due to (or as a consequen	nce of):							
09/	physici the bu	edica		Anemia							_	
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and for the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal of the Pregnant at time of de 9 ☐ Unknown	death 3 🗀	Ectopic pregnanc Other (specify)	у			23d. Date of delivery Month Day Year		
s, P.O.	requires that the dea been signed by the a should be detached t		Part II. Other significant conditions con	ntributing to death but not resul	ting in the u	nderlying cause giv	en in Part I.			ribute to the cause of death?	wn	
Division of Vital Records,	The law requ ate has been page 2 shou	Completed by			_				osy ormed?	Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No	e f	
talF	ysician; T s certifica director, p	Be	25. Was case referred to medical examiner?	lospital:			ace of Death (Ch		22110			
of Vi	y Physi er this c eral dir	e: 10	1 ☐ Yes 2 🗷 No '	1 Inpatient 2 E	8b. Time of	28c. Injury	4 Mursing	Home 5 Resident	dence 6 Other			
on	Attending I er death. ector: After by the funer	Certificate:	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	injury	M 1 🗆	? Yes 2 □ No					
ivis	l or Att after d Direct d in by		4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tov		er or Rural Route Number,		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check 2 Medical Examin	cian: To the best of my knowled er: On the basis of examination a Practitioner: To the best of my	and/or invest	igation, in my opinio	n, death occurred	at the time, date a	and place, and du	e to the cause(s) and manner st	ated.	
	To the within To the comp	2	29b. Signature and title of certifier			29c. License				d (Month, Day, Year)		
	95M		30. Name and address of person who co Weihan Wang, M.D	ompleted cause of death (Item 2	23a) (Type, P	rint)		O, Rockv				
9	Sta Registr		31. Date filed (Month, Day, Year)									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lucille Davis 11:50A M В. 2012 Julv Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Somerford Assisted Living Hagerstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth 5. Social Security Number **Funeral** oct. 29, 1921 Months Days Hours 1 M 2 X 90 **Director** Maruland 215-18-2431 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County with the Maryland be notified at Director 1 X Yes 2 No Hagerstown Washington Md. 10g. Citizen of What Country?" 10f. Zip Code 10e. Street and Number o 23a by Funeral U.S.A21740 207 Jackson Ave. event, the Medical Examiner must Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Lancaster မ Harry Biser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Wynnecrest Dr. Waynesboro, Pa. 17268-9286 LeRoy S. Maxwell Jr. P/R 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1.
Department of Important: If its any injury or or 1 Burial 2 Cremation 3 Removal from State Aug. 3, Smithsburg Crematory 4 Donation 5 Other (Specify) Smithsburg, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. wis MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Lee 38. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Betweer Onset and Death Immediate Cause (Final disease or condition Physician/ DEMENTIA YRS END STAGE Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Be Completed by MYPERTENSIUM MYPERLIPIDEMIA 1 Yes 2 No 3 Probably 4 Tonknown THIRDIDISM OSTED ARTHRITU 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA မှ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Avatural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director: completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUGUST 2, 2012 na mo D18019

State Registrar

DHMH 17 Rev 7/2009

340

32. Registrar's Signature

mill st

M021740

MAGERSTOWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DATTAMO

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012<sup>Year</sup> Month Day Manue 1 D. Ortiz Fabian July 22 1:00 р м Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last hirthday) 8. Date of Birth **Funeral** Days Min (Month, Day, Year) 214-65-6834 39 Director 1 № M 2 🗆 F Dec. 24, 1972 El Salvador Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10c. City. Town or Location Director or 28a-f sl 1 Tes 2 X No MD Montgomery Silver Spring 10e. Street and Number ō 10g. Citizen of What Country? ms 23a or must be r Funeral 2209 Greenery Lane, Apt. T3 20906 El Salvador ural", or items a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black White etc .0 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 Specify: White 1 🗷 Yes 2 □ No Specify Salvadorean "natural", 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates Page 1 and 2 should be filed within 72 hours trnent of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical I jury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mercedes Fabian Selsa Ortiz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa Santos Miranda/Wife 2209 Greenery Lane, Apt. T3, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) July 2012 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Aortic Root Dilatation disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Severe Aortic Insufficiency Sequentially list conditions, Examiner If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (pries a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Pericardial Effusion Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No signed by the a Id be detached f a | Ilnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 No Yes 2X No 1 Yes 25. Was case referred to medical the funeral director. 26. Place of Death (Check only one) Be examiner's Hospital: Other: 1 Tes 2 🔣 No ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ours after death.

neral Director: Af Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Certifying Noxse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) D65953 July 22, 2012 30. Name and address of person Adaku Onukogu erson who completed cause of death (Item 23a) (Type, Print) MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

26 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Imend #8 Per FH G930 8 17 / 2012 JH

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month

3. Time of Death

Physician/ Medical Examiner State Registrar

**Funeral** Director

28a-f show Examiner must be notified the 6

10f. Zip Code 10e. Street and Numbe permit, Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must har Funeral 21740 204 67 Manor Drive Apt. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 X Married ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Heavy Equiptment Operator Be 17. Father's Name (First, Middle, Last) ည Theodoro Maximillion Flores 19a. Informant's Name/Relationship (Type, Print) Nancy N. Flores (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Funeral Ser Pirt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ MAR disease or condition resulting in death) Medical Due to (or s a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death page 2 should be detached to g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed peen 24a. Was an has this certificate 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Hespital: Other: 1 Yes 2 / No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No hours after death. Ineral Director: After 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a Medical 29a. Certifier the only one) 29b. Signature and title of certifie

3:45 PM Flores Martinez 29, 2012 Teodoro 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Meritus Medical Center Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth Month, Day, Year 1963 Months Hours Min 253-15-8364 1 X M 2 □ F Yrs 49 June 4,<del>1962</del> Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h Count 10a. State Director Hagerstown 1 X Yes 2 No Maryland Washington 10g. Citizen of What Country? USA 14 Bace - American Indian. Black, White, etc. Specify: Black 16b. Kind of Business/Industry Construction 18. Mother's Name (First, Middle, Maiden Surname) Essie Mae Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 67 Manor Drive Apt. 204 Hagerstown, Maryland 21740 20c. Location - City or Town, State Green Hill Cemetery Aug. 2,2012 Berryville, Virginia 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 Approximate Interval Between Onset and Death 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1130 OPAL CT HAUERSTOWN MOZITYO MOUHAMAD

State Registrar 31. Date filed (Month

TW-3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 26 per DVR G930 8/16/12 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 07/20/2012 RHONDA ROCHELLE FRAZIER 10:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 314 W. South Street, #A Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** Days Hours Min 1 □ M 2X F 12/05/1958 Director 220-76-0074 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 314 W. South Street, USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Black Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important. If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Certified Nursing Assistant Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Douglas Pumphrey Alda Frazier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Damien Frazier, Sr./son 30420 Revells Neck Road, Westover, MD 21890 #341192 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🛱 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 07/31/2012 Silver Spring, MD 22. Name and Address of Facility Snow en Funeral Home 21. Signature of Funeral Service Los 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter oncerning Cause (Disease or iinjury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dedetached for use as the burial attacks that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year 1 Yes 2 L 9 Unknown ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Rheumatoid Arthritis 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Chronic Ostructive Airway Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 XNo 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier rtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date sig ed (Month, Daf, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD sadal aimur . 46 B Thomas Johnson Drive, Frederick, MD 221702

State

Registrar

31. Date filed (Month, Day, Year)

26 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 July Physician/ Edward Gibson, Jr. Lawrence 23 7:07 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3014 Jennings Road Kensington Montgomery Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 217-28-1767 Country) Director 1 M 2 □ F 77 March 6, 1935 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Directo 1 Yes 2 No MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3014 Jennings Road 20895 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc 1 Never Married 2X Married <u>6</u> Maryland 21215-0036 Specify: White If Yes, Give Year or Dates. 1955-61 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Edward Gibson Jessie Poole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3014 Jennings Road, Kensington, MD 20895 Joan L. Gibson/Wife Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State July 3 2012 Fort Lincoln Cemetery Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Hypoxia Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was de 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ed by the a 9 Unknown 9 🗌 Unknown been signed the should be det Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Coronary Artery Disease, Chronic Kidney Disease Division of Vital Records, Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes 2 N hours after death.

Ineral Director; After this certificate I y filled in by the funeral director, pag 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours To the Funeral C Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date sign mo 2012

Registrar
DHMH 17 Rev 06-2011

State

Registrar's Signature

Inny ST NW Wash DC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

henr

31. Date filed (Month, Day, Year)

	State of Maryland / Department of Health and Mental Hygiene										
		No. 201	2 2556								
Е	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day o o s o Year	3. Time of Death				
and a	Medic	al	Judy A. Gantt		July 18	3 Day 2012 Year	12:05p M				
	Examin		4a. Facility Name (if not institution, give street and number) 4142 Bunker Hill Road Apt 406	4b. City, Town, or Location of Death Cottage City		4c. County of Death Prince George's					
	Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	nplace (State or Foreign				
	Director		144-34-8033 1 □ M 2 🖔 F 66 Yrs.	Months Days Hours Min.	(Month, Day, Yea						
	Id Now	Director	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo	cation	094-19	945   Wash	ington, DC  10d. Inside City Limits				
	arylar a-fsl		MD Prince George's Cottage (				1 ¥ Yes 2 □ No				
	the M or 28 e not	Ö	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cou	untry?				
	within 72 hours after death with the Maryland glehe. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral	4142 Bunker Hill Road Apt 406	20722	Uni	ted State	S				
	items items ner m		11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ameri					
36	after I", or xamir	d by	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 🔀 No Specify:	,	Black, White,					
0	atura cal E	etec	real or Dates.	dent's Usual Occupation	161	Bla  b. Kind of Business/li					
215	n 72 h an "n Medi	<b>Completed</b>	(Specify only highest grade completed) (Give	kind of work done during most of worki O NOT use retired)	ng lot	o. Kind of Business/ii	ndustry				
21	withii giene ner th t, the		12 Legal	L Clerk	Fe	deral Gov	ernment				
pui	s filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)  John Williams		(First, Middle, Maid Mitchell						
2	should be filed v h and Mental Hyg 7 is marked othe traumatic event,										
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		1	ng Address (Street and Number or Rura Glenn Drive Suitl			Code)				
re,	1 and if Hea item other		20a. Method of Disposition 20b. Place of Dispo	sition (Name of		Location - City or 7					
ш	Page nent o int: If		1 ★ Burial 2 □ Cremation 3 □ Removal from State	natory or other place) n Cemetery 07-2	7-2012 B	rentwood,	MD				
alti	permit. Departn Importa any inju		4	. Name and Address of Facility $For$							
<u>m</u>				401 Bladensburg Ro		ood MD 207	722				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between				
~~.	Physician Medical	al Examiner	Immediate Cause (Final disease or condition resulting in death)  End Stale Renal Disease  10 years								
	Examiner		Due to (or as a consequence of):				20 years				
4			Sequentially list conditions, if any, leading to immediate b. Sarcoidosis  Due to (or as a consequence of):		20 years						
	uted nd ransit		Cause. Enter Underlying Cause (Disease or injury that initiated events  c. Cardiomyopathy								
	the burial-transit		resulting in death) Last  Due to (or as a consequence of):								
09/	cate be physic the b	edical	d								
687	eath certifice attending p d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	veni				
Box	eath c atter d for c		in the past 12 months?  1	Ectopic pregnancy Other (specify)		Month Month	Day Year				
Э.	the d by the tacher	hys	9 Unknown								
P.O.	requires that the der been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		tobacco use contribute to the cause of death?					
rds	een si ould	ted			1 L Yes		obably 4 <sup>N</sup> Unknown				
CO	has by	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of				
Ä	n: The icate rr, pag		25. Was case referred to medical		performed 1 Ves 2	No 1 ☐ Yes	2 🖺 No				
/ita	<b>Physician:</b> The lav r this certificate has eral director, page 2	To Be	examiner?  1 Yes 2 No  Hospital:  1 Inpatient 2 ER/Outpatien	26. Place of Death (Check		0 0000000					
Division of Vital Records,	r Attending Phy er death. rector: After this i by the funeral o		27. Manner of Death 28a Date of injury 28b. Time of	28c. Injury at	me 5 🔀 Residence 6 🗌 Other (Specify)  28d. Describe how injury occurred						
on	endin eath. or: Aft the fur	fical	2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No							
visi	l or Attencafter deatl	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, streen building, etc. (Specify)	eet, factory, office		ation (Street and Number or Rural Route Number, or Town, State)					
Ö	pital o		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death of	population data and place an	al alua to the course/	a) and manney as ato	l tod				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier  1	tigation, in my opinion, death occurred at	the time, date and pl	ace, and due to the ca	ause(s) and manner stated.				
	To the vithin To the comp	2	29b. Signature and title of certifier	29c. License number		Date signed (Month,					
			Vorylas Max Coula	DC 15632		07/23/2012	2				
	4500		30. Name and address of person who completed cause of death (Item 23a) (Type, P			<u> </u>					
				N.E. Washington,	DC 20002						
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 32/Registrar's Signature	Med							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 25564 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ JULY 23 2012 Year  $A^{\mathsf{M}}$ 9:53 ROBERT LEE GARNES Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CENTER CLINTON If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth Social Security Number 6. Sex **Funeral** Hours (Month, Day, Year) Country) 577-56-3977 Director 1 ★ M 2 □ F 68 04-09-1944 VA Usual Residence of Decedent 28a-f show 10d Inside City Limits 10c. City, Town or Location 10a. State at with the Maryland Director notified 1X Yes 2 ☐ No MD PRINCE GEORGE'S CLINTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 pe 23a Funeral UNITED STATES 9211 STUART LANE 20735 death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. o, þ 1 Never Married 2 Married ☐ Yes 2X No Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 "natural", or edical Exami 1 Yes 2X No Specify. Specify: BLACK If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) MAINTENANCE GOVERNMENT 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည MARY HENRIETTA SMITH LEANDER RANDOLPH GARNES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16700 HOLLY WAY, ACCOKEEK, MD 20607 CAROLINE LEWIS/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State RIVERDALE ARY CREMATORY 1 Burial 2 X Cremation 3 Removal from State injury or Department o Important: If any injury or once, 4 Donation 5 Other (Specify) 7-25-12 RIVERDALE, MD Signal of Funeral Service Lio 22. Name and Address of Facility POPE FUNERAL HOMES, PA MO1083 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Amenosciciónic Cardiovasculas Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** beaenho Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav 4 Pregnant at time of death
9 Unknown Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by multiple infected daubitus ulcars 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? conhibuting to 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 AVOutpatient 3 DOA ျ 1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident 1 Tes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 07/21/2012 D0062057 450

State Registrar

7503 SURRATTS ROAD, CLINTON, MD 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. SANDRA BANKS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Month Physician/ Janet Mildred Gilotti 0240M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Meritus Medical Center Hagerstown Washington County If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 577-46-5599 **Director** 77 1 □ M 2 💢 F July 11, 1935 Columbia Usual Residence of Decedent 28a-f show 10c. City, Town or Location notified at Director 1 Yes 2 X No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n ō Funeral 142 Southern Oak Dr. U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No es, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Sanitary Commission Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilbert Guy Rice Anna Margaret Swartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Margaret A. Rice-sister 44 Ives St. Martinsburg, WV 25405 permit. Page 1 and
Department of Healt
Important: If item 2;
any injury or con-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 8-2-2012 Smithsburg, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Lice 1331 Eastern Blvd. NorthHagerstown, MD 21742 101 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ ALUIE HYPOXIC disease or condition resulting in death) Medical Examiner BILATERAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ONGESTIVE and -trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Day P.O. | by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ ELEVATED TROPONIN 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed NON ST ELEVATED 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier D70607 MD Name and address of person who completed cause of death (Item 23a) (Type, Print) BAltimore 827 Linden Aue MD KAMESh KUMAR State

Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 02° 2012 3:07 A M Donald Leroy Groomes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospice Dove House If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Director 219-80-5591 1 ▼ M 2 □ F 08/01/1961 MD 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23a or 28a-f sho other treumatic event, the Medical Examinar must be notified at 10d, Inside City Limits Director MD Carroll Westminster 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 USA 1257 Emerald Ridge Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. ģ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) permit. Pege 1 and 2 should be filed within 72 Department of Health end Mental Hygiene. Importent: If item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4 or 5+) plumber plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Freda Davidson Leroy Groomes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21158 1257 Emerald Ridge Drive, Westminster, MD Beth Groomes/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 St Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) eny injury or 08/06/2012 Wesley UMC Cemetery Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examin anding physician and use as the buriel-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed ral director, pege 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No To the Hospitel or Attending Physicien: I within 24 hours effer death.

To the Funerel Director: After this certifics completely filled in by the funeral director, Be 25. Was case referred to medical of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (S) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred Natural 5 Pending Division 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) WESTMINSTER, NO Zels 32. Registrar' Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of IVIA	Cer	tificate of D			. No. 20	112 25567		
п	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death  Month July	2°1 20	3. Time of Death 9:09 P M		
-	Medic Examin	al									
	LAdillill										
	Funeral Director		5. Social Security Number $\begin{array}{cccccccccccccccccccccccccccccccccccc$	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear)	Birthplace (State or Foreign Country)		
			Usual Residence of Decedent	80 Yrs.			March 6,	1932	PA		
	ryland I-f sho ied at	Director	10a. State 10b. County  MD Frederick	10c. City, Town or Loc  Mt. Airy					10d. Inside City Limits  1 🖾 Yes 2 🗌 No		
	the Ma or 28a e notif	Dire	10e. Street and Number		10f. Zip Code		100	g. Citizen of W			
	s 23a	Funeral	#1 Warfield Dr.		21771			USA			
	within 72 hours after death with the Maryland gjene. er than "natural", or items 23a or 28a-f sho the Medical Examinar must be notified at t		11. Marital Status  1 ☐ Never Married 2 ☐ Married  12. Was Decedent Event Armed Forces?  1 ☐ Yes 2 ☒ N	er in U.S. 13. V	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- p Rican, etc.)		e - American Indian, k, White, etc.		
036	rs afte Iral", c	ed by	3 X Widowed 4 Divorced If Yes, Give Year or Dates.	1	I ☐ Yes 2 🔼 No	Specify:		Specify:	White		
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Baltimore, Maryland 21215-0036	ar thank	To Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Maiden Surname) Mae Barnhart			
Iryla	should be fill and Mental is marked or raumatic eve		Robert Calvin Hannah  19a. Informant's Name/Relationship (Type, Print)	10h Mailir	an Address (Street a		ral Route Number, Ci		tate Zin Code)		
Ma	and 2 shou Health and tem 27 is m		Sharon Rea/daughter	.1.			nion Bridg		1		
ore	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □ Removal from State		natory`or other plac				City or Town, State		
Iţim	permit. Page 1 Department of Important: If i any injury or once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee				27/2012 Mt		y, MD Homes, P.A.		
Ba	permit. Departr Imports any injs		Ville 9MV				lvd., Mt.				
,			Approximate Interval Between								
-c	Medical		Immediate Cause (Final disease or condition resulting in death)	Conset and Death							
1	Examiner		Due to (7 as a consequence of).								
	death certificate be executed re attending physician and ed for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								
		Exal	Cause (Disease or injury that initiated events resulting in death) Last								
092		edical	d								
687	ertifica ding pl		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome o	f pregnancy				23d Dat	te of delivery		
Box	requires that the death certificen signed by the attending should be detached for use a	Physician/N	in the past 12 months?  1 Ves 2 No  2 Unknown	Fetal death 3 L time of death 5 D	Ctopic pregnand Other (specify)	у		Mor			
P.O. E	that the c ned by the e detache		9 Unknown  Part II. Other significant conditions contributing to death but	t not resulting in the u	underlying cause giv	en in Part I.	23e Did toba	cco use contr	ibute to the cause of death?		
	ires tha signed Id be d	d by	The state of the s						3 ☐ Probably 4 ☐ Unknown		
ord	The law requires ate has been sign page 2 should be	Completed					24a. Was an autopsy	24b. V	Were autopsy findings available prior to completion of cause of		
Rec	The law cate has	Com				_	performe	ed2 c	death?		
/ital	sician: The certificate irector, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:  1  Inpatier	nt 2 X ER/Outpatier	_ Oth	ace of Death (Che		- 6 Otho	or (Connife)		
of \	ding Phys h. After this funeral d	te: To	27. Manner of Death 28a. Date of injury	28b. Time of		at	1	ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			
ion	Attending Physician: or death. ector: After this certific by the funeral director,	Certificate:	1 Natural   5   Pending   (Month, Day, Year)   Injury   Work?   1   Yes 2   No     1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 3   Yes 4								
Division of Vital Records,	5 # # E		4 ☐ Homicide determined building, etc.		eet, factory, office		City or Town,		er or nurar noute reamber,		
	Hospital of 24 hours a Funeral Dietely filled	Medical	29a. Certifier 1 Certifying Physician: To the best of n (Check 2 Medical Examiner: On the basis of examiner)	amination and/or inves	stigation, in my opinio	n, death occurred	at the time, date and	place, and due	e to the cause(s) and manner stated.		
	To the Hos within 24 hd To the Fun completely	Me	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and the of certifier	best of my knowledge	e, death occurred at t	he time, date and	place, and due to the	cause(s) and m	nanner as stated.  d (Month, Day, Year)		
	F 5 F 0				000	06111	UCE, NO 21702				
	8		30. Name and address of person who completed cause of de	ath (Item 23a) (Type, I	Print)	POBLI	ce red	2170	2		
	Sta	te	31. Date filed (Month, Pay, Year) 32. Registrar		1 1	0 0 0	7	, ,			
	Registr		JUL 2 6 ZUIZI A	W. 1 1. 1.	Darke						

12-03/// Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mark Stephen Harding, Sr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Medical Examiner Mark Steven Harding August 2, 2012 Sr. 2043 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number **Funeral** If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours 1 M 2 F 58 Min 214-60-6213 07/09/1954 Country) MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show Washington Boonsboro death with the Maryland 1 Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19039 Osage Drive 21713 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? White, etc. 1 Yes Pages 1 and 2 should be filed within 72 hours after an one of Health and Mental Hygiene. 4 X Divorced 3 Widowed f Yes, Give Year Yes 2 X No specify: ۵ Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Elementary/Secondary (0-12) during most of working life. DO NOT use retired? College (1-4 or 5+) Baltimore, MD 21215-0036 Security Officer High School 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) å James Edward Harding Bernice Bovey 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Harding, Jr./ Son 5570 Talbot Court, New Market, Maryland 21774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Department of Donation 5 Other Specify: Resthaven Mem. Gardens08/08/12 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer F.H., 1621 Opossumtown Pike, Fred., MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease Examine Death or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physicians: The law requires that the death certificate be executed within 24 hours after death. and hysician/Medical AMENDED 23a, 27, per me, g932 10-10-12 sm X UNPENDED attending physician for use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 23d. Date of delivery past 12 months? Fetal death Month Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. à 23e. Did tobacco use contribute to the cause of death? <u>á</u> 1 Yes 2 No 3 Probably 4 Unknown Completed of Vital Records, After this certificate has been uneral director, page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical Be 26.Place of Death (Check only one) 1 Yes Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other 2 No DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 28f. Location (Street and Number or Rural Route Number, City Could not be To the Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 3, 2012

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

12-05453 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Linda Bari Hobert 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 20, 2012 Hobert 1032 hrs **Medical Examiner** Linda Bari 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Prince George's Fort Washington Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign New York 12/21/1947 Months Days Min. Hours 64 Director 096-36-0885 1 M 2XXF Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X XNo Ft. Washington 28a-f show Prince George's Maryland Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiethe.

tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once rector 10g. Citizen of What Country? 10e, Street and Number USA 9103 Branchview Drive 20744 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1992 1 XX Never Married If Yes, Give Yee Retired 1 X X Yes **Black** 4 Divorced 1 Yes 2 X X No specify: Specify. 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Master Sergeant Baltimore, MD 21215-0036 US Air Force years 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Blanche Askew George Hobert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3950 Senior Lane Sandston, Virginia Theresa B. Bailey / Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 X X Cremation 3 Kalas Crematory 7/25/2012 Edgewater, Maryland nation 5 Other Specify ature of Funeral Socio 22. Name and Address of Facility George P. Kalas Funeral Home PA RILLA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause of ach line Between Onset and Moderal Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been all director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Other Nursing Home 5 Residence 6 Other 1 Yes After 27. Manner of Death 28a, Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Jul 20, 2012 Subject driver in auto auto collision 1 Natural 0915 hrs 1 Yes 2 ✔ No 5 Pending Director: after death. 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) S/B I 95 north of Rt. 210, Oxon Hill, MD within 24 hours at To the Funeral I completely filled determined (Specify) Interstate/Express Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 21, 2012 Jx! 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature 31. Date filed (Month Day, Year State

DHMH 17 Rev 1/2001 OCME 2006

Registra

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2012 Physician/ 6:24AM August **JEAN** ANN HERSHEY Medical 4c. County of Death 4a. Facility Name (if not institution, give street and nun 4b. City, Town, or Location of Death Examiner aurel Regional Hospital Prince Georges Laure 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min (Month, Day, Year) **Director** 234-62-3823 1 M 2 💢 F 71 March 28,1941 Mineral Co. WV Usual Residence of Deceden 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Medical Examiner must be notified at Director 1 X Yes 2 No MD Prince Georges Laurel 10f. Zip Code 10g. Citizen of What Country? ò 10e. Street and Number 23a Funeral 14821 Belle Ami Drive 20707 USA permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 6 þ 1 Never Married 2 X Married Yes 2 X No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🗓 No Specify: Specify: "natural", Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Clerk/Cashier/Manager Retail Dept. Store other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Alonzo Hinkle Erthel Mongold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Darrell W. Hershey, Sr./Husband 14821 Belle Ami Drive Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Aug. 8,2012 Keyser, WV Duling Cemetery 22. Name and Address of Facility Smith Funeral Home 21. Signature of Funer Service Licensee 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner pertension Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Mellitus Diabetes To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) resulting in death) Last ng physician a as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending the detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Live Live Birth 2 Ectopic pregnancy in the past 12 months? Month Day 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has certificate 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 DER/Outpatient 3 IDOA funeral ( 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred a Certificate: 1 Natural 5 Pending after death. Director; Aft the 1 ☐ Accident ☐ Suicide Investigation 3 Suicide 4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined City or Town, State) 24 hours Medical 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Funel

completely fi Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainted as stated.

Certifying Aurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature a dittle of certifie 29c. License number 29d. Date signed (Month, Day, Year, lu Dusen Koad 7300 Vah

Registrar DHMH 17 Rev 06-2011

State

20707

aurel Regional Hospital

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arleen Allen, MD

10

2012

31. Date filed (Month, Day, Year)

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 24 a Mary Elizabeth Knight 2012 10:41 a M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign Birthpia Country) MA 8. Date of Birth **Funeral** (Month, Day, Ye 1 🗆 M 2 💂 Months Davs Hours Vear 79 105-26-3939 Director Feb. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 1127 Old Stone Lane 21012 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🖳 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment.
Important: If item 27 is marked any injury or other transcorrect. 2 John McNelly Agnes M. Thompson 19a. Informant's Name/Relationship (Type, Print) Troy N. Knight/son 1127 Old Stone Lane Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 25, 2012 Metro Crematory Baltimore, MD 4 Donation 5 Other (Special 22. Name and Address of Facility
Barranco & Sons, Signature of runeral Service Live ree P.A. Severna Park Funeral H Severna Park, MD 21146 495 Ritchie Hwy art 1. shock, Enter the disease, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Immediate /ause (Final disease or ondition resulting death) Due to (or as a construence of): Physician. Medica! Examiner equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events Due to (or as a consequence of): burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 2 No the 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş. Ciencer 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director. After this certificate has t autopsy performed? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ည 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No Accident Investigation □ Acciden
 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title 29d. Date signed (Month, Day, Year) D46052 24/12 Who completed cause of death (Item 23a) (Type, Print)
Beil, 10 2000 Medical Parkway anapolis, HD 30. Name and address of perso

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

Therese Lucille Killham State of Maryland / Department of Health and Mental Hygiene 2012 255  1-For State Registrar  Certificate of Death Reg. No.												
Physician/ Medical 1. Decedent's Name (First, Middle,Last)									Date of Dea     Month	Day '	Voar	3. Time of Death
Examir		Therese Lucille Killham							July 21, 2			1100 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Suburban Hospital  4c. County of Death  Montgomery										
Funeral		5. Social Security N	umber 6. S	ex 7. A	ge (In yrs. I	ast birthday)	If Under 1 Year Months Days		Adm		Cour	place (State or Foreign ntry)
Director		355-12-6	172 1	M 2 X F	87	Yrs	Wild it is Day:	Hodis	July	3,1925	I1	linois
Á		Usual Residence of 10a. State	Decedent 10b. County		10c. City.	Town or Locati	on	<u> </u>			T	10d. Inside City Limits
		MD	Montgo	merv			thesda					1 Yes 2 XNo
Maryland 28a-f show any d at once	Director	10e. Street and Num		<i>J</i>	<u> </u>		10f. Zip Code			10g. Citizen of \	What Countr	y?
the Ma a or 28		9707 Old	Georget	own Road	#2607		2081	4		United	Stat	es
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Efficient Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11 Marital Status 1 Never Marrie	d 2 X Marrie	12. Was Deceder Armed Force			s Decedent of His es, specify Cubar		( Specify Yes or No uerto Rican, etc.)		ce - Americ nite, etc.	an Indian, Black,
er deaf	Fun	3 Widowed		1 Yes	2 X No		Yes 2 X No	specify:		Specif	. Wh	nite
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212 212 uld be Ment: mark	9 P	19a. Informant's Ne		ype, Print )		19b. Mailing						ip Code) 20814
MD 21215-0036 ad 2 should be filed within 7 lith and Mental Eygene. m 27 is marked other than aumatic event, the Medical				ım (Spouse	2)				Road, #2	20c. Locatio		
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Ball permit Depart Importinjury	1	24 Signature of Fu	veral Service Lini		0689)	De	ol Fune	ral Ho	me, 10 Ea ersburg,	st Dee	r Parl 77	k Drive,
Physician	1	23. 73 I. Enter th	e disease, or com	plican that cause	d the death.	Do not enter the	mode of dying, s	uch as cardie	c or respiratory arre	est, shock, or he	eart	Approximate Interval Between Onset and
/Medical Examiner	-	Immediate Cause (I		Hypertensive			ovascular Dis	ease				Death
		or condition resulting	gindeath)	Due to (or as e cor	sequence o	f):						
	Jer	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):										
	Examine	cause, Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last  Due to (or as a consequence of).										
and transit		evenus resulting in	Contract Con		· · · · · · · · · · · · · · · · · · ·							
	Medical	UNPENDED		AMENDED								
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x 68 h certi tendin	Physician/	past 12 months	?	4 Pregnant	at time of de	oth —	her (Specify)					
Bo ne deat the at	hys		No 9 Unknow	3 Clare lotter	ath huit not re	neulting in the ur	deduina cause di	ven in Part I	23e. Did	tobacco use co	ntribute to th	ne cause of death?
tal Records, P.O. Box 687, can: The law requires that the death certificate certificate has been signed by the attending pectr, page 2 should be detached for use as the	by F	Part II. Other sign	meant conditions	contributing to de-	au i sout not re	escilling in the ci	locrying caase gr	TOTAL COLUMN				ably 4 📉 Unknown
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COF lawr hasb	Completed									formed?	death?	
Re The tificate		25. Was case refer	red to medical				26.Plac	e of Death (Ch	heck only one)	2   10	· [A] 10.	
Vita ysiciar nis cer directo	o Be	examiner?	2 No	Hospital. 1 X Inpa	tient 2	ER/Outpatient	3 DOA	Other A N	lursing Home 5	Residence (	Other:	
n of Vit ding Physic a. After this	n: To	27. Manner of Deal	h	28a. Date of I (Month, Da	njury y,Year)	28b. Time of		ury at Work?		how injury occ	urred	
tendi death. ctor: ,	atio	1 X Natural 2 Accident	5 Pending Investiga	tion			amb econor escuent	Yes 2 N		/Ctrant and Nur	abor or Dur	al Route Number, City
Division of Vital Records, P.O. Box 687 ran or Attending Physician: The law requires that the death certific ran after death.  **Al Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the control of the cont	Certification:	3 Suicide	6 Could no determin	t be	Injury - At r	nome, farm, stre	et, factory, office	винату, екс.	or Town,		iber or Ruis	a Route Namber, City
Inspit:		29a Certifier	Homicide  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.									
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plant and manner stated.									and place, and	olace, and due to the cause(s)		
	Me	29b. Signature and	title of certifier				29c. Licen		OCME			eth, Day, Year)
0 10		Theo	la Me	Kind	JRG	May.	0.0	.M.E.	COME	July 24	1, 2012	
,	1		ess of p son who M. King, Jr., M		death (Ital Medical F		900 W Baltim	ore Street	, Baltimore, MD	21223		1
S	tate		ith Day Year)	3 Regis	trar's Signal		Carl I					
Regis			26 20	12 Perou	<u> </u>	Opini						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 7:20a M Decedent's Name (First, Middle, Last) 2. Date of Death Thomas Physician/ Eugene Lark 80nth - 20 12 Medical 4b. City, Town, or Location of Death Hagerstown Facility Name (if not institution, give street and number) County of Death Washington **Examiner** 12114 Walnut Point Road Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours MD (mtry) 220-58-4843 10-22-1952 **Director** 1 XM 2 □ F f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Hagerstown MD Washington 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12114 Walnut Point Rd. 21740 U.S.A be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 XMarried 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) metal scrap co. Elementary/Secondary (0-1 12th grade College (1-4 or 5+) truck driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roy Thomas Lark ပ Mary Catherine Sager 1 and 2 should be Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) Vickie Lark spou 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) spouse 12114 Walnut Point Rd. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 8-6-2012 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cedar Lawn Cem. Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Donald Edwin Thompson Funeral Home, P.O.BOX 310 Clear Spring, MD 21722 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final guamous cell carcinoma Physician/ disease or condition Medical resulting in death) lears Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examir Cause (Disease or injury that initiated events resulting in death) Last the burial-trans Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the a should be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed? Yes 2. No Director: After this certificate completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death
Natural
Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Socritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) +, Hagerstown, MD 21740 istrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death Vantage House Health Care Center Columbia Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 523-12-7324 **Director** 1 □ M 2 🖺 F 91 26, 1921 CO Jan. Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Howard Ellicott City 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21043 USA 3010 N. Ridge Road, Apt. C505 items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or iter Black, White, ... White 1 Yes 2 XNo 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANo Specify: 3 ₺ Widowed 4 □ Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 27 is marked other than ' traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Editorial Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Fay Bert Gifford Jessie M. Lomer 19a. Informant's Name/Relationship (Type, Print)
Estelle Marsel/Personal Rep. 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code), 3010~N . Ridge Road, Apt. C505, Columbia, MD Department of Health ar Important: If item 27 is any injury or other trauonce. 21043 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State July 2012 Parklawn Memorial Park 4 Donation 5 Other (Specify) Rockville, MD re of Funeral Service Licensee rancis Adress Collins Funeral Home Inc. 00 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Exter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to infraedate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician bur Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death be detached g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate 1 Yes the funeral director, 25. Was case referred to medical age 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 - Residence 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) Natural 5 Pending work' 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

LITE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 07/22/2012 SELETTA LATA PANNELL MANLEY 05:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Clinton Southern Maryland Hospital Prince George's 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 217-46-9288 Director 1 □ M 2 🛣 F Yrs. 06/29/1948 MD 64 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Silver Spring Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3036 Bel Pre Road, 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify. Specify: 3 XWidowed 4 ☐ Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Representative Sam Kugler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Preston Harrison Pannell Lorraine Voilet Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larlane Pannell-Brown/sister 805 Colby Avenue, Takoma Park, MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Sv 07/26/12 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any leading to him state cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No 1 🗌 Yes Other 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred X Natural work? 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occur red at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

State Registrar

26 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ July 21, Mildred Lee Miller 0115 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 577-52-9223 Director 1 M 2 XF 70 31, 1941 DC Aug. 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2700 Jasper Street SE 20020 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Black, White, etc. 1 🗷 Never Married 2 🗆 Married ò Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 12th College (1-4 or 5+) Switch Board Operator Marriott Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jerome Miller Lula Mae Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 8434 Indian Head Hwy # A2 Fort Washington, Md. Markeisha Miller-GrandDaughter v 30, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Landover, Maryland 4 Donation 5 Other (Specify) Harmony Cemetery 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 20019 lour 4001 Benning Road NE Washington, DC M00560 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between 2 weeks eath Immediate Cause (Final Physician/ Encephalopathy Anoxic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Myocardial Infarction Sequentially list conditions, Due to lor as a conse wence of cause. Enter Underlying burial-transit Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months? Hospital or Attending Physician: The law requires that the death 5 Other (specify) Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🎽 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 XN 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, i Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 XNo မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D65915 July 25, 2012

State Regist<u>rar</u>

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Burko

1500 Forest Glen Road Silver Spring, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Chuanbo Zang, MD
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #28f Per ME G930 8/20/2012 III. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2<u>012</u> **Physician** P<sup>M</sup> 20, 9:12 Eliot Nichols July. Henry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carriage Hill Nursing Home Bethesda Montgomery 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/03/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**⊠**M 2□ F 131-14-1743 88 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Chevy Chase Maryland la or 28a-f sh t be notified Montgomery 1XYes 2 No Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a z should be filed within 72 hours after death with thand Mental Hygiene. 4550 North Park Avenue, Apt. 905 20815 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or iteme ledical Examiner m Black, White, etc. 1⊠Yes 2 No 1944— If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Attorney Law 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be William Nichols Elizabeth Lisse ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20815 19a. Informant's Name/Relationship (Type. Print) Mary Ann Nichols / Wife 4550 North Park Avenue Apt. 905 Chevy Chase, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 07/28/2012 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park 22. Name and Address of Facility Joseph Gawler's Sons LLC. 21. Signature of Funeral Service License 5130 Wisconsin Avenue NW Washington, DC 20016 MLLUNCC0379 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ust only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. L Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 17 Months Cervical Fracture C2 /Medical Due to (or as a consequence of): Examiner Fa11 Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed Weakness Due to (or as a consequence of): Box 68760, buri Physician/Medical Lumbar Spinal Stenosis as the attending phys for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ Coronary Artery Disease 2 No 3 Probably 4 Unknown 1 TYes Completed peen Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2 No page certificate Yes Physician: 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Be examiner: 1 Yes 2 No miner' Other: 4 to Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending Fall at Home 1 ☐ Yes 2 No ai or Attendi s after death. ii Director: A 2 Accident 3 ☐ Suicide investigation 2011 2/17/2011 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (3) 3 Ann Number of Chevy Chase, Mar filled in by 4 Homicide Home within 24 hours af

To the Funeral D

completely filled in Hospitai 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D50534 07/21/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Thomas Masterson MD 6801 Whittier Ave. #200 McLean, VA 22101 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lawrence O. Nkume Month 7 Physician/ 12:49A M 15 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery **Examiner** Washington Adventist Hospital Takoma Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min 214-67-0593 58 **Director** 1 🛛 M 2 🗆 F Nigeria 6-1-1954 28a-f shov 10d. Inside City Limits 10b. Count 10c. City, Town or Location filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at **Funeral Director** MD Montgomery Silver Spring 1 Yes 2 No 3532 Castle Way 10f. Zip Code 10g. Citizen of What Country? 20904 U.S.A. Was Deceue... Armed Forces? Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Nigerian "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Private Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Be 's Name (First, Midd Unknown 18. Mother's Name (First, Middle, Maiden Surname) Unknown ည 19a. Informant's Name/Relationship (Type, Print) (Nephew) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3532 Castle Way Silver Spring MD. Dr. Adindu Ezeocha 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Nigeria 8-6-2012 Family Cem. 4 Donation 5 Other (Specify) 29 Name and Address of Facility Hunt Funeral 908 Kennedy St.N.W. Wash, Signature of Funeral Service Licensee

Francis B Hund CC353 Hunt Wash, D.C. 20011 Part 1. Enter the disease, or complications that caused tile death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 this certificate 2 🗌 No Yes 2 No 1 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 1 ER/Outpatient 3 DOA Inpatient 2 Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work? 2 Accident
3 Suicide 2 No within 24 hours after death.

o the Funeral Director: A Investigation filled in by the Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

Date filed (Month, Day)

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address of person who completed cause of death (Item 23a) (Type, Print)

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vesicy Bylan can	1- For State	ate of Ivialyia		cate of Dea		nai riygione	Reg. No.	21	112 2557
Physician/	Registrar  1. Decedent's Name (First, Midd.	le,Last)				2. Date of	of Death	Year	3. Time of Death
Medical Examine		DAKES				July 2	23, 2012		1902 hrs
	4a. Facility Name (if not institution 14816 Falling Waters		mber)		y, Town, or Location gerstown	of Death	- 1	c. County of Washingt	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last bii		nder 1 Year If Und		of Birth(MM		Birthplace (State or Foreign
Director	215-21-4172	1X M 2 F	23	Yrs.	itris Days Flour		3/11/19	988	Country) MD
nnd show any ace,	Usual Residence of Decedent  10a. State 10b. County  MD Wash	ington	10c. City, Town	n or Location amsport					10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show d at once, rector	10e. Street and Number			10f. 2	Zip Code		10g. Cit	izen of Wha	t Country?
h the	14816 Falling				.795		US		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 X Never Married 2 M	arried Armed Fo	2 X No	If Yes, spe	edent of Hispanic Ori ecify Cuban, Mexicar	n, Puerto Rican, et		White,	American Indian, Black, etc.
s after ral", by	3 VVIdowed 4 DIV	orced If Yes, Give Year or Dates:			2 X No specify		116b		White ness/Industry
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21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	12			owner/c	perator			lands	caping
5-0 led wi lother Cor		, Last)	•			r's Name (First, M		Surname)	
121: d be fillental lental larked		his (Town Bright)	14	Ob. Mailing Addre	Sha	ron King		Situ on Tourn	State Zin Code)
MD 21  MD 22  MD 2 should  MD 27 is max  m 27 is max  TO	19a Informant's Name/Relations Sharon King/r		18		•				
and 2 and 2 lealth item 2 traum	20a. Method of Disposition	lother		of Disposition (N	lame of cemetery,	Date	20c.	Location - C	ty or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1 X Burial 2 Cremation 4 Donation 5 Other S	pecify:	St. St. Churc	Paul's I	utheran ery	07/28/2	012 My	versvi	11e, MD
Balt permit Depart Impor injury	21 Sgnature of Funeral Service	2 M	_						omes, P.A. MD 21702
Physician	23a. Part I. Enter the disease, or failure. List only one cause	on each line.		not enter the mod	le of dying, such as	cardiac or respirate	ory arrest, sh	ock, or hear	t Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)	_	nshot Wound of consequence of):	the Head					
<b>1</b>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence of):					-	
ed nsit	cause. Enter Underlying Cause (Disease or injury that initiated	C							
ecuted and - transit	events resulting in death) Last	d.	consequence of):						
e exec	UNPENDED	AMENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—trans edical Certification: To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Un	he 1 Live bi	ant at time of death	2 Fetal dea 5 Other (S		ic pregnancy		d. Date of d Month	elivery Day Year
P.O. Es that the cigned by the conference of detached		tions contributing to	death but not resulting	ng in the underly	ing cause given in P	art I. 23e			ute to the cause of death?  Probably 4 Unknown
Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sig- completely filled in by the funeral director, page 2 should be ledical Certification: To Be Completed		<i></i>					Was an autopsy performed?	pri de	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
clan: T certification be Co	25. Was case referred to medica	al e			26. Place of Death	(Check only one)			
f Vita Physica or this c	1 Yes 2 No			Outpatient 3	DOA Other	Nursing Home			Other: Scene
Sion of Attending P death. ctor: After After by the funer:	27. Manner of Death  1 Natural 5 Pen 2 Accident Inve	ding FOUND: stigation Jul 23, 2	Day, Year) FO	. Time of Injury UND: 55 hrs	28c. Injury at Wor 1 Yes 2 ✓	<ul> <li>Subject</li> </ul>	scribe how in t shot him		
Division or Spital or Attending sours after death.  Internal Director: After filled in by the func Gertification:	3 ✓ Suicide 6 Cou	ld not be 28e. Place	of Injury - At home, Woods	farm, street, fact	ory, office building, e	or T	ation (Street own, State) alling Wate		or Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		hysician: To the bes	of examination and/or	eath occurred at investigation, in	the time, date and p my opinion, death o	lace, and due to th ccurred at the time	e cause(s) a	nd manner a lace, and du	s stated. e to the cause(s)
To wit	29b. Signature and title of certification	and manner st	lated		29c License number	r	29d.	Date signed	(Month, Day, Year)
	January Vethal 30. Name and address of person	U, MD	ea of death (Hom 22c)		O.C.M.E.		Jul	y 24, 201	2
N.	Pameta E. Southall, M		Medical Examin		Baltimore Stree	t, Baltimore, I	MD 21223		

31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 OCME 2006

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	partment of Health and I	Mental Hygi	ene	
				ertificate of Death	Re	g. No. 201	2 25580
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death
	Medic	al .	Richard Dale Oler		August 5		5:50 p <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
Mary Control	Ermanal		2802 Armacost Ave.  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	21048 If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Carrol	thplace (State or Foreign
	Funeral Director		213-28-9393	Months Days Hours Min.	(Month, Day, ) 02/26/1	Year) Co	buntry) Varyland
	- MC.		Usual Residence of Decedent		02/20/2		10d. Inside City Limits
	yland	cto	10a. State 10b. County 10c. City, Town or I	Location			1  Yes 2 No
	e Mai r 28a notifi	Director	MD Carroll Fin	k <b>sburg</b> 10f. Zip Code	10	Og. Citizen of What Co	
	ith th			21048	"	USA	oundy.
	ems ?	Funeral		. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	erican Indian,
9	or it	by F	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	Black, Whit	te, etc.
203	ural", ural", Il Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 Yes 2 X No Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of wor DO NOT use retired)	king	16b. Kind of Business	/Industry
72	within giene.	S	Elementary/Secondary (0-12) College (1-4 or 5+)	essional Artist		AAI	
g 5	led w Hygi other ent, t	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma		
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, ritem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	욘	Raymond F. Oler	Bett	y Joseph:	ine Klontz	
lan	should and N is ma			iling Address (Street and Number or Ru			
	and 2 s Health em 27		110 1102110 011017 11101		ne Villa		0450
Baltimore,	ge 1a it of H : If ite or oth		1   ■ Burial 2   □ Cremation 3   □ Removal from State   cemetery, comparing the state   cemetery    cemetery   cem	position (Name of rematory or other place)		20c. Location - City o	
ţ	t. Pag rtmen rtant: rjury				09/2012	Timonium,	Maryland
Bal	permit. Page 1 Department of Important: If any injury or once.			22. Name and Address of Facility  412 Washington Rd.	Matmi	ngtor MD	2115 <b>-7</b>
		Н	23a. Part Enter the disease, or complications that caused the death. Do not e				Approximate
	Physician/		shock, or heart failure. List only one cause oveach line. Immediate Cause (Final	991			Interval Between Inset and Death
	Medical		disease or condition resulting in death)  a. Use to (or as a p) sequence of):	ccr '			igi
	Examiner		Congarette	Smithy			40 plusy
	_ #	Examiner	Sequentially list conditions, if my leading to immediate cause. Enter Underlying	0			,
	and and trans	xan	Cause (Disease or injury that initiated events c.	<u> </u>	<del></del>		
_	ite be executed hysician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):				
760	cate b physics the	edic	d				
687	eath certificate attending phy of for use as th	<u>N</u>	IF FEMALE: 23c. If yes, outcome of pregnancy   1 ☐ Live Birth 2 ☐ Fetal death	B  Ectopic pregnancy		23d. Date of de	elivery
Box	leath e atte	Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☐ No  4 ☐ Pregnant at time of death	is ☐ Other (specify)		Month	Day Year
	nat the dea	Phys	9 Li Unknown	- underlying access along in Doct I	00. 5111-1		o the cause of death?
, P.O.	Physician: The law requires that the death certifica this certificate has been signed by the attending pland director, page 2 should be detached for use as the state of the control of the control of the center of the certification.	by	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Fart i.			Probably 4 Unknown
rds	equire een s hould	eted					utopsy findings available
Records,	has b	Completed			24a. Was an autopsy perform	y prior to	completion of cause of
Ä	ician: The la certificate ha rector, page		25. Was case referred to medical	26. Place of Death (Che	perform 1 Yes 2	No 1 ☐ Ye	es 2 No
/ita	ysician: is certific director,	To Be	examiner?  1  Yes 2 No	Othor		nce 6  Other (Spe	cify)
of Vital	g Physer this		27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury at	28d. Describe hov		
On	Attending Ph or death. ector: After th by the funeral	fical	2 Accident Investigation	M 1 Yes 2 No			
Division	il or Attending after death. Director: After d in by the fune	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str. City or Town,	reet and Number or Ro , State)	ural Route Number,
	Hospital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	the appropriate the time date and place	and due to the cour	co/c) and manner as s	stated
	Hospital 24 hours a Funeral I	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inv	restigation, in my opinion, death occurred	at the time, date and	d place, and due to the	cause(s) and manner stated.
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Σ	only one) 3 L. Certifying Nurse Practitioner: To the best of my knowled 29b. Signature and title of certifier	29c. License number		9d. Date signed (Mon	
	/		Jam W. milleton	725443		8/4/	2012
	MCI		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	4. 4		
	. 0.,		Is how modeleto any	e, Print) 688 Poole Rd H	l'estra in	ster M	102117
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1 0 2012  August A. Sauce	,			
		खा	TOULD IN A COMMENT OF LIBRAGE				

Please Type or Print in Black Lydelible by Engure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8079 Newcomb Court Anne Arundel Pasadena Social Security Number If Under 1 Year 7. Age (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** Hours (Month, Day, Year) 245-23-9242 Director 1 🗆 M 2 🛂 51 Yrs Aug. 27, 1960 NC Usual Residence of Decede 28a-f shov 10a. State 10c. City. Town or Location the Maryland at 10d. Inside City Limits Director notified MO Anne Arundel Pasadena 1 🗆 Yes 2 🔀 No 10e Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 8079 Newcomb Court 21122 USA items Page 1 and 2 should be filed within 72 hours after death in ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. er than "natural", or the Medical Examin þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Nurse Medical other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Robert Strickland Frances Strickland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Jessica Stead/Daughter 8079 Newcomb Court Pasadena, MD 21122 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy. 21. Signature of Funeral Service Licenses P.A. Severna Park Funeral Home <u>Severna Park, MD 21146</u> 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart laikure. List only one cause — each line. Approximate Interval Between Priset and Depath S Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or Injury that initiated events resulting in death) Last use as the burial-trar Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Por Month Day Year Pregnant at time of death signed by the all P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has autopsy director, page 2 After this certificate Be ( 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 No Hospital မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 24 hours after death.

Funeral Director: After this etely filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work?
1 Yes 2 No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c-License numbe 29d. Date signed (Month, Day, Year) Name and address of perso 0

DHMH 17 Rev 06-2011

Registrar

26 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>D</sup>2012 July Philip Russo 23 10:57 P <sup>M</sup> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 112-18-7254 1 🗶 M 2 🗆 F 86 9/17/1925 New York 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🛣 No Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2546 Arbor Court 21035 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Defense Engineer years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Russo Mary Papparello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David F. Russo/ Son 2546 Arbor Court, Davidsonville, Maryland 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Veterans Cemetery 7/30/12 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signator 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final purat disease or condition resulting in death) Due to (or as a consequence of) Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) eunen o pregnancy \_\_ Fetal death delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 4 ☐ Pregnant at time of death g ☐ Unknown 1 Yes 2 No Did tob cco use contribute to the cause of death? 2 No 3 Probably 4 Winknown

Physician/ Medical Examiner

and

To the Hospital or Attending Physician: The law requires that the death certificate be executed

after death.

Director: After this certificate

within 24 hours a

director,

funeral

filled in by the

Division of Vital Records, P.O. Box 68760

Physician/

Medical

**Examiner** 

**Funeral** 

**Director** 

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items 23a

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"natural"

al Hygiene.

of Health and Mental Hygi item 27 is marked other other traumatic event, it

if it Page 1

Department c Important; If any injury or

of Health and Mer

must be notified at

Examiner

the Medical

Director

Funeral

Completed by

Be

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Examine burial-transi ate has been signed by the attending physician page 2 should be detached for use as the buria

Physician/Medical

Certificate: To Be Completed by

Medical

ΙF

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 [

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy

death?

		TES 2 LAND TE 16
5. Was case referred to medical	26	6. Place of Death (Check only one)
examiner? 1 X Yes 2 No	Hospital: 1 Na Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Spe
7. Manner of Death		Injury at 28d. Describe how injury occurred work?

Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

fell down

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif

Name and address of person who completed cause of death (Item 23a) (Type, Print) Herbert, mD JOSEPh

State Registrar

101

 Date filed (Mont) L 26 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ 15, July Vernon Rainey 11:35 a<sup>M</sup> Frank Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Oxon Hill Prince Georges 506 Barrymore Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number Age (In vrs. last birthday 8. Date of Birth **Funeral** 12-23-1928 579-30-5684 **Director** 1 🖾 M 2 🗆 F 83 Pennsylvania Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Oxon Hill 1 🔀 Yes 2 🗌 No Md. Prince Georges 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? ems 23a or r must be r Funeral death with 20745 U.S.A. 506 Barrymore Drive items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. "natural", or ite Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ IX Yes 2 1953–1974 If Yes, Give 1953–1974 Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after Specify: Black 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed 1 and 2 should be filed within 72 hour of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working **Veterans** life. DO NOT use retired Elementary/Secondary (0-12) **12th** College (1-4 or 5+) Supply Clerk Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gladys Hembry Frank Rainey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 1800 Palmer Road, #426 Ft. Washington, Md. Faye M. Rainey - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Page 1 Md. Veterans Cemetery 07-24-2012 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Home 21. Signature of Funeral Service License 10583 Middleport Lane, White Plains, Md. 20695 2da Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Spontaneous Cardiac Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Old Age Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death the g Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed be det Completed by Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Pulmonary Fibrosis 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 XNo has page 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🗌 No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 23, 2012 D69719 1º IM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. Lerner - 9300 Dewitt Loop, Fort Belvoir, Virginia 31. Date filed (Month, Day Year) State

DHMH 17 Rev 06-2011

Registrar

ESTA G L' DAVA

Millette

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 31/9 pm Physician/ Month Rosella Reeder Elizabeth Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Plata La Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Country Director 218-24-2365 1 □ M 2 💢 F 85 Maryland 06/14/1927 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Charles Waldorf 1 ☐ Yes 2 🏻 No 10e. Street and Number "natural", or items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20602 3586 Old Washington Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Force Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Adrian Trotter Mary Blanche Guy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara W. Reeder/Daughter 20 West 69th St., New York, NY 10023 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other? 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Ronation 5 Other (Specify) St. Waldorf, MD Peters Ch. Ce 08/10/12 21. Sig of Funeral Service Licens 22. Name and Address of Facility Raymond Funeral Svc., P.A. 20646 5635 Plata, MDM01517 Washington Ave., La 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, duty, eading to immedicause. Enter Underlying Cause (Disease or injury Due to for de a cone Exami the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as t nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Por in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PNo မ 1 🗌 Yes 💢 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature apptitle of 146979 Mi 100% 30. Name and address of person who completed cause of death (Item 23a) (Typer Print) Washington Lead. Lufe 203A. Walton 20602 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#15 per FH State of Maryland / Department of Health and Mental Hygiene State AACO HEALTH DEPT. CMH 7/30/12
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FRINI Month. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 963 Running Brook Way Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Yea March 25, Months Days Hours Min. Year) 054-03-7382 92 Director New York 1XXM 2 □ F 1920 Yrs Usual Residence of Deceden er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 963 Running Brook Way 21401 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1★★ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 □ Divorced Year or Dates. WW II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Attorney and Investigator 5 Government Service 1\_ other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George John Serini Clara Sweden permit. Page 1 and 2 should be Department of Health and Munoriant: If item 27 is market any injury or other transmetic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1070 Cameron Wood Drive Ada, Michigan John Serini/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 7/26/2012 Baltimore, Maryland 21. Signatur uner Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home od 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KILUM E Physician/ disease or condition resulting in death) OUG-ESTIV Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): 9 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
9 Funeral Director: After this certificate has been signed by the attending physician and burial-transit that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? Day 4 ☐ Pregnant a
9 ☐ Unknown Pregnant at time of death 5 Other (specify) 2 🗌 No is certificate has been signed by the a director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Completed 1 T Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 65 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L 26 2012 istrar's Signature State Registrar

Amend #31 per AA Co. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Heakth Dept 7/26/2012 lo State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month MONIO 4:15 P M 07 012 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ANNE ARUNDEL ANNAPOLIS 805 BRIDGEPORT WAY If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) Director 559-50-9055 1 □ M 2**X** F 8/17/1922 JAVA, INDONISIA 89 Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location the Maryland Director must be notified 1 Yes 2X No ANNAPOLIS MARYLAND ANNE ARUNDEL ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral UNITED STATES 805 BRIDGEPORT WAY 21401 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc. ō à 1 Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: WHITE "natural", Completed 3X Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the OWN HOME HOME MAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of 2 ALBERTUS WHILLEM VERMEER DJHINA KENONG traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important, If item 27 is any injury or other tractonce. LYDIA SUGIHARA/DAUGHTER 805 BRIDGEPORT WAY ANNAPOLIS, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 ESAPEAKE CREMATION 1 Burial 2 X Cremation 3 Removal from State 7/27/2012 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS HELFENBEIN & NEWNAM CREMATION & FUNERAL CARE Signature of Funeral Service Lice 814 BESTGATE ROAD, ANNAPOLIS, 23a. Dart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. he iner ement disease or condition Medical resulting in death) Due to or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the at Id be detached fo P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnods been 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) ensim 24a. Was an autopsy performed has page 2 Viers Sucral Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital မ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital within 24 hours Medical 29a. Certifier Exitifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

50 State

Registrar

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32. Regist ar's Signature

highway

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Milwerkrohn

±7/26/2012

SUFFREY

31. Date filed (Month, Day, Year)

D68693

suite 400 Annapolis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donald Vincent Schlimme, Jr. Month 6.51AM July Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death
Prince George's 4b. City, Town, or Location of Death Lanham Doctors Community Hospital 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Nov. 24, 1933 Davs Hours 212-30-9093 1 M 2 D F 78 Maryland **Director** Yrs Usual Residence of Decedent ms 23a or 28a-f shormust be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Yes 2 □ No Maryland Prince George's College Park 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 3315 Marlbrough Way United States or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. "natural", 3 Widowed 4 Divorced If Yes, Give Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) l Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Professor Higher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental I marked o မ Mary Christine Nelson Donald Vincent Schlimme, Sr. and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3315 Marlbrough Way College Park, Maryland 20740 Lois J. Schlimme -wife item 27 20a. Method of Disposition
1 ☐ Burial 2 🖸 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Department of Important: If it any injury or o once. cemetery, crematory or other place)

Metropolitan Crematory 7/25/2012 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee, forMaldav. Addissifiator Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Acute hypoxic respiratory failure Medical Due to (or as a consequence of) **Examiner** Septic shock Sequentially list conditions, i.e. ny, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Ventricular tachycardia Cause (Disease or injury that initiated events resulting in death) Last use as the burialthe attending physician Physician/Medical Pneumonia requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Cardiomyopathy Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law this certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **V** No 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Amare

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Emilio E. Loyola Sotomayor  $P^{M}$ July 2:10 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Rockville Shady Grove Adventist Hospital Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) Hours Months Days (Month, Day, Year) **Director** 624-24-1804 70 1 🛛 M 2 🗆 F June 3, 1942 Chile Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. the Martinal Examination 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20878 22 County Court Chile 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 

Yes 2 □ No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Chilean Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Officer Chilean Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Emilio Loyola Sofia Sotomayor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Spouse) Danuta Jablonska 22 County Court, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot July Dat 5, cemetery crematory erother place)
Metropolitan
Crematory 1 Burial 2 X Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Alexandria, Virginia 2021 21. Signature of Funeral Service Fensee 22. Name and Address of Facility DeVol Funeral Home, M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 thet tipe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition hours Medical resulting in death) Due to (or as a consequence of) Examiner 48 hours Pneumonia Sequentially list conditions, if any, leading to immediate cause. Ent. r. Ind. rying Examiner Due to (or as a consequence of) Chronic Lymphedema Years Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Years Coronary Artery Disease To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Year 2 No g 🗌 Unknown g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Obesity 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Obstructive Sleep Apnea 24a. Was an nas autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No ျပ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 X Natural injury within 24 hours after death

To the Funeral Director; A

completely filled in by the i Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) D37024 July 23, 2012 ame and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar David G. Srour, M.D.,

26 2012

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

9901 Medical Center Drive, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 2012 8:52 AM MABLE ROSE SIMPSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY STLVER SPRING HOLY CROSS HOSPITAL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** PUEBLO NUEVO Director 75 1 🗆 M 2 🗓 F 578-74-5626 12-4-1936 PANAMA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director ms 23a or 28a-f sl must be notified 1 X Yes 2 □ No SILVER SPRING MONTGOMERY MD 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Completed by Funeral 20901 IIS 408 Greer Ave ıral", or items 2 | Examiner mus death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married 1 Yes 2 X No permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: PANAMANIAN Specify: HISPANIC "natural", 3 ₩ Widowed 4 □ Divorced Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur ther traumatic event, the Medical I Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE SECREATARY 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MICHAEL BRYAN AGNES REYNOLDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13306 VANESSA AVE, BOWIE, MD 20720 RUBEN SIMPSON JR./SON item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of I Important: If it any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL CEMETERY 7-27-12 LANDOVER, MD 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service Lice Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ PULMONARY EMBOLUS Medical Due to (or as a consequence of) ME Examiner HIP FRACTURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed AT HOME that initiated events use as the burial-tra resulting in death) Last Due to (or as a consequence of attending physician Be Completed by Physician/Medical ANEMIA Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) 1 Yes 219 Unknown 4 ☐ Pregnant : 9 ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes RECENT ASPIRATION PNEUMONIA After this certificate has been signeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 24a. Was an PAST CEREBROVASCULAR ACCIDENT autopsy performed? Yes 2 ANd 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Other: ၉ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury
(Month. Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 X No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 X Accident Unk 5 Pending 6/28/2012 FALL AT HOME Investigation 24 hours after death Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 408 GREER AVE.SILVER SPRING.MD 20901HOME Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of ertifier 29c. License number 29d. Date signed (Month, Day, Year, D41624 45m cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed DR PATRICK 1.31. Date filed (Month, Day, Year) PATRICK MURPHY 1500 FOREST GLEN ROAD, SILVER SPRING, MD 20910 Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JULY 18 2012 10:45P M RICHARD GLENN SHAFFER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY POTOMAC 11717 AMBLESIDE DRIVE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 07 / 12 / 1934 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 ₹M 2 □ F 281 30 7678 CANTON, OHIO Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XX No POTOMAC Director MONTGOMERY MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 USA 20854 11717 AMBLESIDE DRIVE 23a Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If filem 27 is marked other than "natural" ~ :- any lnjury or other traumatic events. 12. Was Decedent Ever in U.S. Armed Forces?

AMYes 2 No
If Yes, Give 1960—
Year or Dates: 1986 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 1 Never Married 2 Married 1 ☐ Yes 22 No Specify Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DENTIST DENTAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ LEE J. SHAFFER KATHERINE ZETTLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BARBARA S. SHAFFER 20854 11717 AMBLESIDE DRIVE, POTOMAC, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ARLINGTON NAT L CEMETERY ARLINGTON VA 4 ☐ Donation 5 ☐ Other (Specify) UNK 22. Name and Address of Facility
ADVENT FUNERAL SERVICES, 7211 LEE HWY, FALLS
CHURCH VA 21. Signature of Furnaval Service Licensee #997 Approximate Interval Between Onset and Death ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one be Immediate Cause (Final disease or condition resulting in death) ancer **Physician** STa /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner and burial-tran Due to (or as a consequence of) ours after death. here this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Wes decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check online) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

24 hours a Funeral I

within 2 the 0

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner

31. Date filed (Month, Day, Year) 32. Regi 5 2012

🗗 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 13 PM Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 9. Birthplace (State or Foreign Accokeek If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday)
Yrs. 8. Date of Birth Funeral Social Security Number 1 M 2 🗆 F (Month Day, Ye Days **Director** Carolina Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ISA 12. Wee Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: than "natural", 3 Widowed 4 Divorced Specify: Blac Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Fire Demitment is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Belk Sheard-Wife Strausberg 113 ACCOKEEK MD 20607 Method of Disposition

1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Annandale leasant Valleu 28 12 Signature of Funeral Service License 22. Name and Address of Facility Greene Funeral Home, Inc Franklin Street, Alexandria, VA 22314 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate Interval Betwoonset and De shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition arterioscle Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner ancei Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as: IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe after death.

Director: After this certificate 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending 1 Yes 2  $\square$  No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of co ZIJM 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death . 2012 Physician/ July 20, Keith Bernard Smith 11:45 $p^{M}$ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery Co. If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min. (Month, Day, Year) 217-96-3697 **Director** 1**X**] M 2 □ F 66 01-08-1946 Guyana Usual Residence of Decede 28a-f shov 10c. City, Town or Location ŧ 10a. State 10d. Inside City Limits Director Examiner must be notified 1 X Yes 2 No Md. P.G. Capitol Heights or 10e. Street and Numbe 10g. Citizen of What Country? 23a 4503 Heath Street 20743 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Black Specify: "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Self-Employed Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental File of Health and Mental Filem 27 is marked o ၉ Kenneth Smith Cynthia Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Moseley - Sister 7936 Fiske Avenue, Lanham, Maryland 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If its any injury or of 1 Burial 2 Cremation 3 Removal from State Riverdale Pk Crematory 7-30-2012 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor, II Funeral Home Kono 10583 Middleport Lane, White Plains, Md. 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final PSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Shock Sequentially list conditions. if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to jor as a consequence of): Exami and -tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 SS IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 1 ∐ Yes ∠∟ g ☐ Unknown the Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ρ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After (Month, Day, Year) work? 1 Natural 5 Pending injury 2 Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060 60 07-21-12 DI, MO

DHMH 17 Rev 06-2011

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State

Registrar

A 160 450

Seji

32. Registr 's Signature

TA HMINA

Silverspy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Unevert

ETTP C. L DOM

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81. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Н	Dharisis	/	Registrar  1. Decedent's Name (First, Middle, Last	,		inicate of B	- Cutin	2. Date of Deat		3. Time of Death
	Physicia Medic	al		a Kay SMITH				July		2012 0451 M
	Examin	er	4a. Facility Name (if not institution, give : Meritus Medical			4b. City, Town, or Hagerst	Location of Death		4c. County o Wash	of Death Lington
	Funeral		5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	□ M 2 <b>X</b> F	47 Yrs.			Sept. 1	.8,1964	Maryland
	ryland I-f sho ied at	ctor	10a. State 10b. County		. City, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 🏖 No
	he Ma or 28a e notif	Dire	Maryland Washingt  10e. Street and Number	.011	Hagerstov	10f. Zip Code			10g. Citizen of W	
	s 23a nust b	Funeral Director	13131 Kaiser Ridg	e Road		21740-	1015		U.S.	
036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates.	l l	as Decedent of His Yes, specify Cubar		ecify Yes or No- Rican, etc.)		- American Indian, k, White, etc. white
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Maryland 21215-0036	filed v tal Hyg d othe event,	To Be	17. Father's Name (First, Middle, Last)					e (First, Middle, N		)
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Ma	1 and 2 should be file of Health and Mental F fitem 27 is marked of other traumatic ever		Myrtle M. Smith -		13731	Address (Street a Kaiser F	nd Number or Hur. Ridge Roa	al Route Number, .d,Hage1	city or lown, St	Maryland 21740
Baltimore,	Page 1 and ment of He and I item ant: If item ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	ob. Place of Dispos cemetery, cremi agerstown	atory or other place	e) ! T-, 1	30		City or Town, State
Salti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	90		Name and Addres		Minnich		. Home , Maryland 21740
	40200		23a. Part 1. Enter the disease, or comp	lications that caused the d						Approximate
ı	Physician/		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.	Avter	w Dis	ease			Interval Between Onset and Death
ز	Medical Examiner		resulting in death)	a. Due to (or as a con	equence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to as a cons		avt to	aiding			IM
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· Dialete	s N	cellita	2			100
	cate be executed physician and s the burial-transit	al E	resulting in death) Last	Due to (or as a con-	sequence of);					,
200	ficate t g phys as the	<b>f</b> edical		d						
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours afferd death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pre 1  Live Birth 2  4  Pregnant at time 9  Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	4		23d. Date Mon	e of delivery th Day Year
5	that the ned by	by Pr	Part II. Other significant conditions co	ntributing to death but no	t resulting in the un	derlying cause give	en in Part I.	23e. Did tob	pacco use contril	bute to the cause of death?
ras,	een sig ould b							1 □ Ye	es 2 No	3 ☐ Probably 4 ☐ Unknown
Vital Records,	The law re cate has be page 2 sh	Completed						24a. Was ar autops perforr 1 \square Yes	ned? pi	/ere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No
Ea	sician: certific irector,	Be c	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		Lou	ce of Death (Chec			<u> </u>
N OT V	ding Phys th. After this funeral d	cate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year	ER/Outpatient 28b. Time of injury	28c. Injury	4 □ Nursing Ho	ome 5 Reside 28d, Describe ho		
DIVISION OF	al or Atten s after dear I Director: d in by the	Certificate;	3 Suicide 6 Could not be 4 Homicide determined					28f. Location (Str City or Town		r or Rural Route Number,
-	he Hospita in 24 hours ne Funera pletely fille	Medical	(Check 2 Medical Examir	ician: To the best of my kr ner: On the basis of examin e Practitioner: To the best	ation and/or investig	gation, in my opinior	n, death occurred a	t the time, date and	d place, and due	to the cause(s) and manner stated.
	To t To tl		29b. Signature and title of certifier	20		29c. License		I	_	(Month, Day, Year)
			30. Name and address of person who co	ompleted cause of death (	Item 23a) (Time Dr		2525		1-30	:-2012
TI	V-1		Dr. Muhammad Wase				own, Mar	yland 21	740	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Si	AL AL	and I				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 25 Meriano Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JUTY 20 2012 Year Son Ae 1:50a м Physician/ Bo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Rockville **Examiner** 4Montegomery Hebrew Home of Washington 8. Date of Birth 10% 12 Fey 129 18 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In vrs. last birthday Social Security Number 343-62-8589 **Funeral** Min. 1 □ M 2 🗗 F Hours 93 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho idical Examiner must be notified at Director 1 Yes 2 No MD Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20854 Funeral USA 10408 Bit And Spur Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: Asian If Yes, Give 3 → Widowed 4 □ Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Own Home Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ermit. Fage 1 and 2 should be file. Cepariment of Health and Mental Hemportant: If item 27 is marked any injury or cert. Yang Suk Hyun ည unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10408 Bit and Spur Lane Potomac, Md 20854 Ellen Lee/Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 7/23<sup>Date</sup> 7/23 Gatery, of atome after Silver Spring, Md 1 Burial 2 ☐ Cremation 3 ☐ Remova 4 Donation 5 Other (Specify) PARILDE AD RENALDI FUNERAL SERVICE, P.A. uneral Strvice Licen 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph\_sician/ emention disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and 1 Exami Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 SS 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be 1 🗌 Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7-20-12 D0064871 Mines 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD 20852 MD Montrose 6121 Fazli 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

26 2012

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month restor 6:30 am OSR 2013 Medical 4a. Facility Name (if not institution, give sweet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 2747 Kaetzel Road Knoxville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number Sex. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 0-34-4968 Months Days Min (Month, Day, Year) Hours 1 0 M 2 🗆 F **Director** 84 Yrs March 13, 1928 Georgia 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector 1 X Yes 2 No Georgia Warner Robins Houston Δ ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral <u> 205 Gardner Drive</u> 31088 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Fo Black, White, etc. 1 Never Married 2 Married þ 2 🗌 N Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 X Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Military Air Frame Repair Tech is marked other event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 George Lee Shell Melvie Irene Bearden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Frassmann/Daughter 2747 Kaetzel Road, Knoxville, Maryland 21758 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date . Page 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 08/03/12 Douglasville, Georgia Sunrise Mem. Gardens of Funeral Service License 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 1800 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the burial-trai Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [≥ Records, 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed<sup>a</sup> certificate 2 🗆 No Yes & 1 Tyes Division of Vital • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certificietely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) residence Hospital 2 7 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred Ratural 5 Pending work? 1 Yes 2 No ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Dav. Year

State Registrar

31. Date filed (Mont)

street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Into English E for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Thomas Wayne STINE  $J_{u1y}^{Month}$ Physician/ <sup>Day</sup> 2012 10:33a. M 29 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 143 King Street Hagerstown . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Min. Nov. 11, 1949 219-54-0984 62 Maryland **Director** Usual Residence of Decedent 28a-f show 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a State 10c City Town or Location 10d Inside City Limits Maryland Washington Hagerstown 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 143 King Street 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black White etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify white Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) labor City of Boonsboro Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Millard Hill Stine Goldie Louise Stine other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Vickie L. Stine - Wife 143 King Street, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State  $^{31}_{2012}$ Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home abults 415 East Wilson Blvd., Hagerstown, Maryland 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Recurten S9 Kamaus disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) eral Director: After this filled in by the funeral di Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title D0068995 2012 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Yong Tang W) 1/30 0Pal Hagerstown, MD 21740 1/30

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Monta

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Clara Magdalen Stankiewicz	Clara	Magdalen	Stankiewicz
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		1- For State Registrar		Certi	ficate of L	Death			eg. No.	
Physicia Medical Examir		Decedent's Name (First, Middle 1)		a Magdela	an Stan	kiewicz		2. Date of Dea Month July 31, 2	Day Year	3. Time of Death 1743 hrs
		4a. Facility Name (if not institution Meritus Medical Center)	-	umber)		. City, Town, or Lo Hagerstown	ocation of Deat	h	4c. County of Washingt	
Funeral Director		5. Social Security Number 022-24-7333	6. Sex	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hi Hours Mi	n.	th(MM/DD/YYYY) 25,1932	Birthplace (State or Foreign MA
' any	ļ	Usual Residence of Decedent  10a. State 10b. County			own or Location			i i i i i i i i i i i i i i i i i i i		10d. Inside City Limits
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with the Maryland ms 23a or 28a-f sho be notified at once.	I Director	1792 North	Hensign F	oint		3442	29		U.S.A	
after death	by Funeral		arried Armed F  1 Yes  orced If Yes, Give Ye  or Dates:	2 X No	If Yes	Decedent of Hispa , specify Cuban, I es 2 No	Mexican, Puert specify:	o Rican, etc.)	White, Specify:	White
11215-0036 d be filed within 72 hours fental Hygiene. rarked other than "natur event, the Medical Exam	Completed	15. Decedent's Education (Special Elementary/Secondary (0-12)	cify only highest gra		during mos	Usual Occupation of working life. If Homemake	OO NOT use re		16b. Kind of Bus	iness/Industry
Y 2 ₹ 2 ₩		17. Father's Name (First, Middle,					3.Mother's Nam		Maiden Surname)	
	To Be	Dominic Be 19a. Informant's Name/Relations	hip (Type, Print )				and Number or		nber, City or Town	
alth alth		Stanley J. Sta	nkiewicz			N. Hensi		nt Cryta		FL 34429 City or Town, State
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and Important: If item 27 is nijury or other traumatic.		1 Burial 2 X Cremation 4 Donation 5 Other Sp	pecify:	rom State cre	matory or other thsburg	Cremato	ry Aug	2, 2012	Smithsb	urg, Maryland
Balt permit Depart Impor injury		21. Signature of Funeral Service	Licensee	M0141	14 I	ne and Address o 25 Bradb			is Funer	al Home aryland 21783
Physician /Medical	4	23a. Part I. Enter the disease, or failure. List only one cause	on each line.		o not enter the	mode of dying, su	uch as cardiac	or respiratory arr	est, shock, or hear	t Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	-	uries a consequence of):		_				Death
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ed Isit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	_ ` _	a consequence of):						
		UNPENDED	d. AMENDED							_
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Box 68 e death certi the attendin ed for use as	Physician/Medical		4 Pregr	nant at time of death own	. —	(Specify)			1	()
P.O. Box 68: ires that the death certificates that the death certification is signed by the attending.	اھ	Part II. Other significant conditi	ions contributing t	o death but not resu	ulting in the und	erlying cause giv	en in Part I.			ute to the cause of death?  Probably 4 Unknown
ords, w require ts been si should b	Completed							24a. Was autop	sy pri	ere autopsy findings available or to completion of cause of
tal Reco	E OS							1 ✓ Yes		ath? ✓ Yes 2 No
Vital Rec ysician: The l his certificate b	å	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 EF	R/Outpatient 3		f Death (Check ther 4 Nursi		Residence 6	Other:
J Of Jing Ph	tion: To	27. Manner of Death  1 Natural 5 Pend	28a. Date Jul 31,	of Injury 28	8b. Time of Inju 510 hrs		at Work? s 2 ✓ No		how injury occurred of a motor veh	icle involved in a
Divisi tal or Att as after de al Direct lled in by	Certification:	3 Suicide 6 Coul	a not be	e of Injury - At home		factory, office bui	lding, etc.	28f. Location (		or Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Pt	nysiclan: To the bearing	st of my knowledge, of examination and	death occurre					
To with	ğ	29b. Signature and title of certifie	and manner s	stated.		29c. License	number		29d. Date signed	(Month, Day, Year)
S on		Pati (h	- Pago	,en		O.C.M	.E.		August 1, 20	012
2/11/2		<ol> <li>Name and address of person Patricia Aronica-Pollal</li> </ol>		se of death (Item 23 ant Medical Ex		00 W. Baltimo	ore Street, I	Baltimore, M	D 21223	
Sta Regist	-	31. Date filed ( <i>Month</i> , <i>Day</i> , Year)	Server 32. R	egistrar's Signature	ukad					

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			amend #8 PState of 9		drtmefit of H tificate of D			201	2 25500
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31	Physicia Medic	al	Marilyn M. Schreiner		I		07 <sup>nth</sup>	3Î <sup>y</sup> 20Î	
العبياء	Examin	er	4a. Facility Name (if not institution, give street and number, Transitions Healthcare		4b. City, Town, or Sykesvi			4c. County of Dec	
	Funeral Director		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9. B	irthplace (State or Foreign ountry)
			Usual Residence of Decedent	73 Yrs.			09/15/‡	336	NE
	aryland a-f sh	Director	MD 10b. County Carroll	10c. City, Town or Lor Sykesvill					10d. Inside City Limits 1   Yes 2 □ No
	a or 28	I Dir	10e. Street and Number	DAVERATIT	10f. Zip Code		11	0g. Citizen of What C	
	ath with mit ms 23 must	Funeral	7309 Second Avenue  11. Marital Status 12. Was Deceden	Currie II C 40 1	21784		-if . V( N)-	USA	
36	ge 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	Armed Forces  1 Never Married 2 Married 1 Yes 2  If Yes, Give	? No	Vas Decedent of His f Yes, specify Cubar I □ Yes 2 <b>X</b> No	n, Mexican, Puerto F		14. Race - Am Black, Wh Specify:	ite, etc.
21215-0036	hours hatura dical E	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupa			16b. Kind of Busines	nite s/Industry
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Maryland	should be filed vand Mental Hyg is marked other raumatic event,	υ	Roger W. Armstrong			Maxine M		_	
	id 2 sho salth an n 27 is er traui	T)	19a. Informant's Name/Relationship (Type, Print) Richard Schreiner/son	19b. Mailir 2552	ng Address (Street a Albert Ri	nd Number or Rurai .11 Road,	Westmin	City or Town, State, 2 ster, MD	<sup>(ip Code)</sup> 21157
nore	age 1 and ent of Heal nt: If item ? y or other		20a. Method of Disposition  1 □ Burial 2X Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, cren Carroll C	natory or other place	e) !		20c. Location - City of Hampstead	
Baltimore,	permit. Page 1 Department of Important: If any injury or once.		21. Signature of Euheral Service Lightnee	22	. Name and Address	s of Facilia Pritt	s Funer	I Nome a inster, M	nd Chapel
			23a. Part Enter the disease, or complications that caus	ed the death. Do not ente					Approximate
×	Phyllician/		shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition	usclerunz	Cartion	ascula	- Dis	ease	Interval Between Onset and Death
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687	eath certificat attending ph		IF FEMALE: 23c. If yes, outcom	e of pregnancy					
Box 687	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M	in the past 12 months?	2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)	/		23d. Date of d Month	elivery Day Year
Js, P.O.	uires that i in signed b uld be det	ρ	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause give	en in Part I.			o the cause of death?  Probably 4
Division of Vital Records,	The law require: ate has been si page 2 should b	Completed					24a. Was an autopsy perform	prior to ned? death?	
tal F	ysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?			ce of Death (Check	1 \(\text{ Yes 2}\) only one)	1 ∐ Ye	es 2 🗌 No
of Vi	S S	욘	27. Manner of Death 28a. Date of in			4 Nursing Hor	ne 5 Resider	nce 6 Other (Spe	cify)
ono	Attending Physician: or death. ector: After this certific by the funeral director,	Certificate:	1 Natural 5 □ Pending (Month, D 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	ay, Year) injury	work?		od. Bedombe nov	rinjury occurred	
Divisi	al or Attens s after deat al Director: ed in by the		Homicide determined 28e. Place of Ir	njury - At home, farm, stre etc. <i>(Specify)</i>	eet, factory, office	2	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After thi completely filled in by the funeral	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of Medical Examiner: On the basis of Urse Practitioner: To	examination and/or invest	tigation, in my opinior	n, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
	To the I within 2 To the I comple		29b. Signature and title of certifier		29c. License	number	29	od. Date signed (Mon	
	6 m		30. Name and address of person who completed cause of	death (Itam 22c) (Time 5	Deposit N	43725		1/3/11	7
			Taria Mahmood	1 9 /	Print) Ridge R	Road	Westn	unster 1	ND 21157
	Stat Registra		31. Date filed (Month, Day, Year)  32. Regis	trar's Signature	_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G930 8/27/2012 JH State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 "Ä"ua 1. Shryock 2355 Merdith Claude Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany Allegany Health Nur. & Rehab. Ctr. Cumberland Birthplace (State or Foreign Country) MD 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. 1 XM 2 - F ₩öѷ<sup>®</sup> <sup>Ү</sup>° 1918 Director 217-10-1921 93 Usual Residence of Decedent or 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 730 Furnace Street USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify and Mental Hygiene. is marked other than "natural", WWII Specify: white 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ministry Pastor Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hilmportant. If item 27 is morning or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lorena A. Twigg William Charles Shryock 19th 2001 Address (Street and Number or Rural Route Number, City or Town, State, Zip 42 Evitts Creek Road Bedford 19a. Informant's Name/Relationship (Type, Print) 15522 Judy Hampson daughte 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Rocky Gap Veterans Cemetery 1 M Burial 2 Cremation 3 Removal from State 8/6/2012 MD Flintstone 4 ☐ Donation 5 ☐ Other (Specify) Signatur of Funeral Service Licer 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the dise so, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence(o Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Kunknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cantilying Nurse Practioner To the basis of examination and or investigation, in my opinion, death occurred at the time, date and place and due to the reason and one manner as that id Continues Practionar To the best of my knowledge 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 2 D0033280 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person M.D. 625 Kent Ave. Ste. 101 Cumberland, MD 21502 32. Registra s Signature AUG 1 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Umstot Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alleghany Cumberland Western Maryland Health System If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) Director 215-34-4213 1 XM 2 □ F 77 Yrs 05/22/1935 Keyser, WV 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if frem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 26726 135 Southern Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X☐ No Specify. 3 Widowed 4XXDivorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Plumbing Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alma Gertrude Staggs Floyd Nelson Umstot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 North 4th Street, LaVale, MD 21502 Randy Umstot (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State WVU Memorial Vault 07/30/12 Morgantown, WV 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WVU Human Gift Registry Signature of Funeral Service Licensee PO Box 9131, Morgantown, WV 26506 23a. Part 1. Enter the disease se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Yes a No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 / Mo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month,

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

AUG 10

2012

person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | 1 | 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 19, Day 2012 Year Physician/ 01:05 A M Anita R. Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Clinton Southern Maryland Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min **Director** 1 🗌 M 2 🕱 F 579-40-9415 8<sup>rs</sup> DC Aug. 4, 1930 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 10a. State Director 1 X Yes 2 No Maryland Prince George's Clinton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 9211 Stuart Lane 20735 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 African If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 🗆 Widowed 4 🙀 Divorced <u>American</u> the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th Red Cross traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o မ 0zro Nixon Ruth L. Ridgely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Arlette Clinton - Niece 12414 San Jose Lane Lusby, Maryland 20b. Place of Disposition (Name of cemetery crematory or other place)
Washington
National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. Aug. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Suitland, Maryland Signature of Funeral Service Lice Stewart Funeral Home, Inc. 22. Name and Address of Facility Stewart M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ATheroscleratic ardivarular Discase Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a co sequence of Exami use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After the Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 1 within 2 To the 1 (ivings for a) a (of for washington MD 2076g 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

Box 68760

P.O.

Records,

Division of Vital

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201<sup>ea</sup> 1:30P M Gladys Estelle Wright Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bedford Court Rehab Skill Fac-Silver Spring If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7, Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 07-20-1930 Days New Jersey 1 □ M 2 🔀 F 82 Director 47-24-0873 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho dical Examiner must be notified at should be filed within 72 hours after death with the Maryland Director Germantown 1 Yes 2 No MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral 20874 USA 19505 Fetlock Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12 Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Margaret Corbin John Taylor Important: If item 27 is mark any injury or other traumatic once. 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19505 nFe±10ck priye
GermanFown, Maryiand 20874 19a. Informant's Name/Relationship (Type, Print) Claudia Kelliehan (Dgtr) Page 1 and 2 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition permit. Page 1 and Department of H cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 07-24-2012 Funeral Home Clinton, MD Lee 4 Donation 5 Other (Specify) Signature of Funeral Arvice icensee Rallon Williams, II Funeral Service, 5202 Princetons Delight Dr., Bowie, MD 20720 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final Physician/ Arteriosclerotic Cardiovascular Disease Years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it as a single limit of the cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to or as a consequence of requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Day Month Pregnant at time of death g 🗌 Unknown Division of Vital Records, P.O. ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ 1 Yes 2 XNo 3 Probably 4 Unknown Hypertension, Failure to Thrive, Dementia Completed 24b. Were autopsy findings available 24a. Was an The law has page 2 prior to completion of cause of performed? Yes 2 XNo this certificate 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Bedford Other: 4 Nursing Home 5 Residence 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 No M Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

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State Registrar

Syamsundar Rajan 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

9801 Georgia Ave., Silver Spring, Registrar's Signa

29c. License number

D53367

Suite

29d. Date signed (Month, Day, Year)

7-23-2012

20906

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ \_a <sup>M</sup> 2012 9:20 Barbara A. Whitlock Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery <u>Takoma Park</u> Washington Adventist Hospital Social Security Number If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign last birthday Funeral Country) (Month, Day, Year) 1 □ M 2 🖾 F Hours Min. 75 **Director** 576-36-8620 Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1X Yes 2 No DC Washington 10g, Citizen of What Country? 10f. Zip Code 10e, Street and Number ò or than "natural", or items 23a or the Medical Examiner must be Funeral 20002 United States 2021 2nd Street NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 K No by Saltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 🛣 No Specify. Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15 Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) within 72 alth and Mental Hygiene.
27 is marked other than "r r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 7th Unemployed Unemployed Be filed 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If Item 27 is marked cany injury or other traumatic eve 2 Margaret King Fred Hooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tyrone L. Whitlock/Son 2021 2nd Street NE Washington DC 20002 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 7-31-2012 4 Donation 5 Other (Specify, Brentwood, Maryland 22. Name and Address of Facility John T. Rhines Funeral Home aral Sen M01592 3005 12th Street NE Washington DC 20017 a. Part 1. Enter the disease, or co etions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between WOMA WITH Onset and Death ERVIC Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the bunal-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 🖟 No Yes 2 🗷 26. Place of Death (Check only one) the funeral director, 25. Was case referred to medica Be examiner? Hospital 1 🗌 Yes 2 10 No 1 Dinpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ARMIN

State Registrar

31. Date filed Month,

451

DHMH 17 Rev 7/2009

WASHINGTON

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SLADUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ Year Day 1322 CHARLENE WHITMORE 2012 Medical Y.IIII. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE HOWARD ELLICOTT CITY Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 338-34-6213 Director 1 M 2 X Yrs JUNE 7, 1935 AK 77 or 28a-f show notified at with the Maryland Director 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No ELLICOTT CITY MD HOWARD 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 8938 TOWN & COUNTRY BLVD #C 21043 US items 2 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?
1 Yes 2 No Black, White, etc ō 1X Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) alth and Mental Hygiene.

27 is marked other than raumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) **HEMATOLOGIST** PRIVATE Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ CHARLES WHITMORE LOUISE MCCLURE Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trai KAREN LEWIS/ DAUGHTER 8938 TOWN & COUNTRY BLVD #C, ELLICOTT CITY, MD 2104B Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, GRACELAND CEMETERY 7-28-12 MILWAUKEE, WI of Funeral Service Lice Sign 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. any in MOIDE 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ ENAL disease or condition Medical resulting in death) Due to (or as a consequence of Examine Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or injury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No Hospice 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: After the full of the full 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after

To the Funeral Direct

completely filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MID 2Jm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA ABBAS 63 SYED Q. MD CEDAR

DHMH 17 Rev 06-2011

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Registrar

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199		30. Name and addr	ess of person who	completed cause of d	eath (Item	23a) (Type, P	rint)WALTER BETHES	R REED NAT	CIONAL N 0889	MILIT	rary M	EDIC	CAL CENTER
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State Registrar 31. Date filed (Month, Day, Year) 1 2012

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death August Physician/ Medical 4c. County of Death Facility Name (if no institution/di or Location of Deat **Examiner** n/a 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 H Age (In yrs. last birthday) If Under Funeral Months Hours Min (Month, Day, Year) Country) 453-75-8524 **Director** 1 □ M 2**X** F 36 Yrs June 30, 1976 Taiwan 28a-f shov 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location ms 23a or 28a-f sho must be notified at with the Maryland Director 1 Yes 2X No MD. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 6629 Charlesway USA death v items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian permit Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other trainments. Examiner Black, White, etc. þ 1 Never Married 2 Married 2 X No ☐ Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify Asian Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Medicine Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Lee Jen Wu Wen Rong Wu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William S. Anderson/ Husband 21204 Towson, MD. 6629 Charlesway 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 8-14-12 Towson, MD. Hilltop Service Co. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Electron darking Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and burial-trai Due to (or as a consequence of) attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed should peen Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No After this certificate has funeral director, page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 힏 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury 1 🗷 Natural  $5 \square$  Pending 2 No Accident Investigation the within 24 hours af er dealt To the Funeral Director Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number. filled in by determined Hospital Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, RES - 000 NINTH, TWO THOUSEVE 30. Name and address of person who complete 0

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25609 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Year Month Mary Ellen Brown 10 August 1:17 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 949 Chestnut Manor Court Curtis Bay Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 5-23-1929 218-24-6261 83 MD Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c, City, Town or Location Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 949 Chestnut Manor Court 21226 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes Give Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Hospital Admissions 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellen Amelia Trott Robert Elmer Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Platt/daughter 949 Chestnut Manor Crt, Baltimore MD 21226 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) Metro Crematory 8/11/2012 Catonsville MD 21. Signature of Emeral Strvice Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 M01364 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death

Ph. sician/ Medical **Examiner** 

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P.O. Box 68760

Division of Vital Records,

or Attending Physician:

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permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is many injury.

Baltimore, Maryland 21215-0036

Examir Physician/Medical the nse ō detached signed by t 2 Completed funeral director, Be ပ္ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. Certificate:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2. N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniurv ■ Natural 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

29a. Certifier

only one)

3

HOSPITAL DRIVE GLEABORA

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Mary Beadenkopf Anne August 5:41 P. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard 10999 Hickory Ridge Road Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 216-05-7226 Director 1 🗆 M 2 🔀 F Maryland 09 - 30 - 192091 show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Howard Columbia 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö must be Funeral 23a United States 10999 Hickory Ridge Road 21044 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 þ 1 Never Married 2 Married 1 Yes 2 XNo
If Yes, Give
Year or Dates. Saltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify. Specify: White "natural", Completed 3 ★ Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. alth and Mental Hygiene. 127 is marked other than traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mildred Long George Keys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i Christine Hamill - daughter 10999 Hickory Ridge Rd., Columbia, MD 21044 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once, 5 Other (Specify) Meadowridge Mem. Park: 08-08-2012 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signatu MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause (Disease or injury Due to for as a domesquerice of, signed by the attending physician and dbe detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy this certificate has page 2 No 1 Yes Yes Hospital or Attending Physician: 25. Was case referred to medical upletely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 1 \(\simeg\) Yes Hospital 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After Natural Accident (Month, Day, Year) 5 Pendina Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier crtifying, Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

(Check only one 29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatu

2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nuyse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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SYJO Know NORTH DV. \$260 Colombia HD 21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year John Julius Baker Aug 2012 Medical 2:30 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 906 Elton Avenue Dunda1k Baltimore Co. Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Min (Month, Day, Year) 213-36-2443 **Director** 1 ★ M 2 🗆 F March 22,1939 73 Yrs Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Dunda1k 1 🗌 Yes 2 ဳ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 906 Elton Avenue 21224 United States items Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
sant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1957-631 Yes 2X No Specify. 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Elementary/Secondary (0-12) College (1-4 or 5+) Bayview Medical Ctr. Patient Transporter 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Goldie G. Green Harry L. Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 Elton Ave. Baltimore, Maryland 21224 19a. Informant's Name/Relationship (Type, Print) Mrs. Margaret J. Baker(Wife) 20a. Method of Disposition Department of H Important: If ite any injury or ot 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Hilltop Service Corp. 8/13/2012 Towson, Maryland 4 Donation 5 Other (Specify) Signatur Juneral Service License Gregory Reed Duda-Rucks funeral Home of Dundalk, 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, o complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ CANON disease or condition 21 MUNTUY Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year signed by the a 1 Yes 2 L 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should Completed 1 See 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy Hospital or Attending Physician: The perform death? 1 ☐ Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 IDOA pletely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work death. 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) woll 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENTRAF 31. Date filed (Month, Day, Year, State Registrar

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Baltimore, Maryland 21215-0036	ge 1 an of He tof He tof He or oth		20a. Method of Disposition 1   Burlal 2 Cremation 3		CE	lace of Disp emetery, cre	ematory or c	other place		Date				-	own, State	
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b.	Physician/Medical	IF FEMALE:													
9 x	th cert tendir	ian/l	23b. Was decedent pregnant	23c. If yes, outcome 1 Live Birth	2 Fetal	Ideath 3	Ectopic	pregnanc	;y			1	23d. Date		,	. 4
Bo	e deat the at thed fo	ysic	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of de	eath 5	Other (s	pecify)					Mon	ıtn	Day Year	ŗ
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Division of Vital Records,	tal or s after al Direction		4 El Nomicide determined	building, etc	:. (Specify)	1				С	lity or Town	ı, State,	;)			
	dospit 4 hour unera	Medical		sician: To the best of ner: On the basis of ex												er stated.
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	<b>2</b> ≥ <b>2</b> ⊗		29b. Signature and the dicertifier	1/1/10				3845					ust 6			
	. /		30. Name and address of person who c	completed cause of d	eath (Item	23a) (Type						nug				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 8 Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12731 Haskell Lane Bowie Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 19, 1954 7. Age (In vrs. last hirthday) Funeral 9. Birthplace (State or Foreign Days Hours Country) Maryland Director 214-66-2468 1 □ M 2 🗗 F 58 June Usual Residence of Deced r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 😾 No Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12731 Haskell Lane 20716 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 2 1 Never Married 2 x Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 daycare provider daycare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward A. Brown Pauline Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12731 Haskell Lane; Bowie, MD 20716 Raeford Bivens - husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Ronald S Wade 22. Name and Address of Facility State Anatomy Board Signat 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day 124 hours after death.

Funeral Director, After this certificate has been signed by the a feueral director, page 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 N 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 3 ☐ Suicide 5 Pendina work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical To the Hospi within 24 hou To the Funer completely fil 1 🖬 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practitioner: To the basis of my knowledge death occurred at the time, date and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D003658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 SH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 2:45 AM Name (if not institution, give street and number) Town, or Location of Death County of Death Howard If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Aug 16 Pay, Year) 57 Min. Maryland 54 217-66-7326 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21202 201 E. North Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 X Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify. 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation un 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marion Hicks Linwood Preston Brown Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 E. Preston St #603; Baltimore, MD 21202 Robert Hicks - brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date

Physician/ Medical **Examiner** 

Physician/

Medical

10a. State

MD

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

	4 Donation 5 🛭 Other Specify	in state									
	21. Signatur of Fune of Service License Ronald 8	Director	22. Name and Address of Facility Stat 655 W. Baltimore S			21201					
	shock, or heart failure. List only on Immediate Cause (Final disease or condition		enter the mode of dying, such as cardiac or  Adem Cancuma  Edificulty Virus		L	Approximate Interval Between Onset and Death					
niner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	se.									
dical Exan	Cause (Disease or linjury that initiated events resulting in death) Last	C	:								
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 4  Pregnant at time of death 9  Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year					
ted by PI	Part II. Other significant conditions co	ntributing to death but not resulting in t	the underlying cause given in Part I.		_	the cause of death?					
Comple				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of					
Be	25. Was case referred to medical examiner?		26. Place of Death (Check of	only one)							
2	1 🗆 Yes 2 🗖 No	lospital: 1 Inpatient 2 ER/Outp	patient 3 DOA Other: 4 Nursing Hom	ne 5 Residence	6 ☐ Other (Spec	rify)					
	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		ne of 28c. Injury at 28	3d. Describe how inju							
al Certi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	8f. Location (Street a City or Town, Stat		ral Route Number,					
Medical Certificate:	(Check 2 Medical Examin	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier	Jame	29c. License number	29d. D	ate signed (Month	n, Day, Year) 2 2012					
	30. Name and address of person who co	pmpleted cause of death (Item 23a) (Type Parks) 201-109	D3064-1 pe, Print) Back River Neck A	Road Es	SSEX M	1 ayland 21221					

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend #30 Per DVR G930 8/13/2012 Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Agust 2012 Clifford Elmo Bates 9:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Hospice of St. Marys, Inc. Callaway St. Mary's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Day, Dec 27, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. I925 Virgi<u>nia</u> **Director** 229-26-0780 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director St. Marys Great Mills 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20634 Funeral 19744 Flat Iron Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk carpenter carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virgie Nettie Osborne Pearlie Henry Bates

20b. Place of Disposition (Name of cemetery, crematory or other place)

 $A^{M}$ 

Physician/ Medical **Examiner** 

and I-transit

anding physician are as the burial-

signed by d

page 2 s certificate this

I hours after death. uneral Director: After the ad filled in by the funeral

within 24 hours To the Funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

19a. Informant's Name/Relationship (Type, Print)

20a. Method of Disposition

29b. Signature and title of certifier

30. Name and address of p

Jennifer

Eva Durkin - daughter

1 Burial 2 Cremation 3 Removal from State

Medical Certificate: To Be Completed by Physician/Medical Examiner

4 Donation 5 Other (Specify	)								
21. Signature of Fune al Service License	1 1 Di		22. Name	and Address of Fac	cility Sta	te Anato	omy	Board	
Ronald 8	wage, Dire	ctor	655	W. Balti	more	St; Bal	timo	ore, MD	21201
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final	lications that caused the cause of pach line.								Approximate Interval Between Onset and Death
disease or condition resulting in death)	a	consequence of	-11 120	of the	sew				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury									
that initiated events resulting in death) Last	Due to (or as a od.	consequence of)							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1  Live Birth 2 4  Pregnant at t 9  Unknown	Fetal death	3   Ectopie 5 Other (					23d. Date of de Month	livery Day Year
Part II. Other significant conditions co	ntributing to death but	not resulting in t	he underlyin	g cause given in Pa	art I.				the cause of death?
						24a. Was a autops perfor 1 Yes	sy	prior to death?	topsy findings available completion of cause of s 2  No
25. Was case referred to medical examiner?		<u>-</u>		26. Place of D	eath (Check	only one)			
1 ☐ Yes 2 XNo	Hospital: 1 🗌 Inpatien	t 2 🗆 ER/Outp	atient 3 🗌	DOA Other: 4 🗌	Nursing Hor	me 5 Reside	ence 6	Other (Spec	sity) the solve
27. Manner of Death Natural 5 Pending Accident Investigation			28b. Time of 28c. Injury at 28d. Describe how injury occur					y occurred	Horse
3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	- At home, farm (Specify)	e, farm, street, factory, office  28f. Location (Street and Number or Rural City or Town, State)			ral Route Number,				
29a. Certifier 1 Certifying Phys	ician: To the best of m	y knowledge, de	ath occured	at the time, date ar	nd place, and	d due to the cau	ise(s) ar	nd manner as st	ated.

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Hospice of St Mary's, Inc Callaway, MD

HU05575

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18210 Stokes Dr; St. Inigoes, MD 20684

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

08-05-2012

State Registrar on who completed cause of death (Item 23a) (Type, Print)

32. Pagistrar's Signature

Schmidt

AUG 1 3 201

29a. Certifier (Check

Director

Completed by Funeral

Be

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Physician/ Medical

Examiner

**Funeral** 

**Director** 

28a-f show

State Registrar		Cer	artment of Health and I tificate of Death	Reg. No.				
Decedent's Name (First, Middle, Las	st)		imodeo or Bodari	2. Date of Death		3. Time of Death		
٨	Vellie Ther	esa Cornwe	ell	Month August	08. 2012	8:00 pM		
Facility Name (if not institution, give	street and number)		4b. City, Town, or Location of Death		4c. County of Dea	th		
Casey Ho			Rockville			ntgomery		
577-30-5724 6. Security Number 6. Security Number 1	ех	n yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day,	1927 Was	thplace (State or Foreign hington, DC		
. State 10b. County	1	Oc. City, Town or Loc	eation			10d. Inside City Limits		
aryland Montg	omery		Derwood	l		1 🗆 Yes 2 🗶 No		
Street and Number			10f. Zip Code	10	g. Citizen of What Co			
16416 Kipling Ro			20855		u	.s.A.		
Marital Status	12. Was Decedent Eve Armed Forces?	lf If	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
Never Married 2 ☐ Married  ■ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1	☐ Yes 2 🗶 No Specify:		0	White.		
15. Decedent's Ed	ducation		ent's Usual Occupation		6b. Kind of Business			
(Specify only highest gra Elementary/Seconday (0-12)	ade completed)  College (1-4 or 5+)		rind of work done during most of work O NOT use retired)	ding		•		
0	,		Homemaker		- Ow	n Home		
Father's Name (First, Middle, Last)	Gallerizzo	Gallacha		ne (First, Middle, Ma Catimo Pa	aiden Surname) I <b>Piccioni</b>			
. Informant's Name/Relationship (Ti								
ichard W. Cornwe		l l	g Address (Street and Number or Rur <b>6 Kipling Road. D</b>	_ *				
Method of Disposition		20b. Place of Dispos	sition (Name of		0c. Location - City or	***		
1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			latory or other place)	1/2012	Silver Spr	ina. MD		
Signature of Funeral Service Licens	,	22	Name and Address of Facility His	nes-Rinal	di Funera	l Home, Inc.		
Part 1. Enter the disease, or comp shock, or heart failure. List only or			r the mode of dying, such as cardiac			Approximate		
mediate Cause (Final		3.0				Interval Between		
ease or condition	Muocari	dial. Inha	rction		69	Interval Between Onset and Death		
	a. Myocaru Due to (or as a c	dial Infa onsequence of):	rction					
ulting in death)	Due to (or as a c	onsequence of):	rction		(8)			
ulting in death)  juentially list conditions, ny, leading to immediate so. Enter Underlying	d	onsequence of):	rction					
Juentially list conditions, by leading to immediate so. Enter Underlying use (Disease or linjury initiated events	b. Due to (or as a c	onsequence of):	rction					
quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease or iinjury t initiated events	Due to (or as a c	onsequence of):	rction					
pease or condition sulting in death)  quentially list conditions, any, leading to immediate use. Enter Underlying, use (Disease or iinjury at initiated events sulting in death) Last	b. Due to (or as a c	onsequence of):	rction					
quentially list conditions, must leading to immediate use. Enter Underlyfit guse (Disease or infjury at initiated events withing in death) Last  EMALE:  . Was decedent pregnant in the past 12 months?  1	b. Due to (or as a c  Due to (or as a c  Due to (or as a c  d	onsequence of):  onsequence of):  onsequence of):  pregnancy  Fetal death 3			23d. Date of de Month	Onset and Death		
quentially list conditions, ny, leading to immediate so. Enter Underlying use (Disease or iinjury t initiated events alting in death) Last  EMALE:  Was decedent pregnant in the past 12 months?  1  Yes 2  No 9 Unknown	b. Due to (or as a c  d. Live Birth 2 [ 4 Pregnant at ti 9 Unknown	onsequence of):  onsequence of):  onsequence of):  pregnancy  Fetal death 3 me of death 5	Ectopic pregnancy Other (specify)		Month	Onset and Death  livery Day Year		
quentially list conditions, ny, leading to immediate so. Enter Underlying use (Disease or iinjury t initiated events alting in death) Last  EMALE:  Was decedent pregnant in the past 12 months?  1  Yes 2  No 9 Unknown	b. Due to (or as a c  d. Live Birth 2 [ 4 Pregnant at ti 9 Unknown	onsequence of):  onsequence of):  onsequence of):  pregnancy  Fetal death 3 me of death 5	Ectopic pregnancy Other (specify)		Month	Onset and Death  livery Day Year		
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ulting in death)  quentially list conditions, ny, leading to immediate isc. Links Underlying use (Disease or imjury t initiated events ulting in death) Last  EMALE:  Was decedent pregnant in the past 12 months?  1	Due to (or as a c  Live Birth 2  4 Pregnant at ti 9 Unknown  Ontributing to death but	onsequence of):  onsequence of):  onsequence of):  pregnancy  Fetal death 3 me of death 5	Ectopic pregnancy Other (specify)	1  Yes  24a. Was an autopsy perform 1  Yes 2	Month  acco use contribute to  2 🗶 No 3 □ P  24b. Were au prior to	Onset and Death  livery Day Year  the cause of death?  robably 4 □ Unknown		
Juling in death)  Juling in death)  Juling in death)  Juling in death)  Juling in death in the past 12 months?  1	b. Due to (or as a c  1 d.  23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown  ontributing to death but  Hospital:	onsequence of):  onsequence of):  onsequence of):  pregnancy  Fetal death 3 me of death 5	Ectopic pregnancy Other (specify)  nderlying cause given in Part I.  26. Place of Death (Chec	1 ☐ Yes  24a. Was an autopsy perform 1 ☐ Yes 2 k only one)	Month  acco use contribute to 2 X No 3 P  24b. Were au prior to death? 1 Per	Onset and Death  livery Day Year  o the cause of death?  robably 4 Unknown  topsy findings available completion of cause of		
quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease or imjury it initiated events ulting in death) Last  EMALE: . Was decedent pregnant in the past 12 months? 1	Due to (or as a c  Live Birth 2  Hospital:  I pregnant at ting Unknown  Ontributing to death but  Due to (or as a c  Live Birth 2  Hospital:  I pregnant at ting Unknown  I pregnant at ting Unknown  I pregnant at ting Unknown  Ontributing to death but  Due to (or as a c	onsequence of):  onsequence of):  onsequence of):  pregnancy       Fetal death	Ectopic pregnancy Other (specify)  nderlying cause given in Part I.  26. Place of Death (Chec	1 ☐ Yes  24a. Was an autopsy perform 1 ☐ Yes 2 k only one)	Month  2 M No 3 P  24b. Were au prior to death? No 1 Yes	Onset and Death  livery Day Year  o the cause of death?  robably 4 □ Unknown  topsy findings available completion of cause of		

Examine attending physician and for use as the burial-transit Physician/Medical cate has been signed by the page 2 should be detached Completed by Be completed filled in by the funeral director, 유 Certificate:

Medical only one) 29b. Signature and title of certifier 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP, Debrah Miller, 31. Date filed (Month, Day, Year) AUG 1 3 2012 32. Registrar's Sign State

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) R143201 8.9.12

City or Town, State)

6001 Muncaster Mill Road, Rockville, Maryland 20850

Registrar

Please Type or Print in Black Indelible Inks Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Augustus Caesar 09 Day 01:15 PM 2012 145 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death UNION Memorial Hospita 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) (Month, Day, 220-18-4323 **Director** 1 M 2 □ F 124 1925 MARVIAND show 10a State 10b. County 10c. City, Town or Location notified at **Funeral Director** 10d. Inside City Limits BALTIMORE 28a-f MD 1 Yes 2 No or 10e. Street and Number 10g. Citizen of What Country? Examiner must be 23a THE ALAMEDA U.S.A. items 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1943

If Yes, Give 01) Black, White, etc Completed by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: BLACK 3 Widowed 4 Divorced De filed with.

"vtal Hygiene.

"ther than "natu.
"A Medical Ex Year or Dates. 19 46 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MAINTENANCE traumatic event, the ORTER 17. Father's Name (First, Middle, Last Ceasar Be 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ LEWIS LOUISE HAWKINS HAWKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  ${\it 21218}$ 1 and 2 s of Health item 27 DENISE CAESAR 2833 THE ALAMEDA BALTIMORE, MARY IAND DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date. permit. Page 1
Department of I
Important: If it
any injury or of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 20 2012 OWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 22. Name and Address of PANE DERRICK C. JONES FIA, P.A nature of Funeral Service Licenses BALTIMORE 14945. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Cardiomyopathy Medical resulting in death) Examiner (Respiratory Failure) Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Dementia Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the 38 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Year ed by the a P.O. s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has autopsy performed? 1 Yes 2 No prior to completion of cause of death?

1 
Yes 2 
No page certificate 25. Was case referred to medical Division of Vital Hospital or Attending Physician: the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital ≥X No ၉ 1 Tyes Other: 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural s after death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) AT2438946 08/09/2012 30. Name and address of person who completed o use of death (Item 23a) (Type, Print) Union Memorial Hosp. Washington MO Baltimore MD 31. Date filed (Month, Day, Year)

Registrar

AUG 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Baltimore Birthplace (State or Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Age (In yrs. last birthday) Social Security Number **Funeral** 1 🗆 M 2 🖭 Days Hours 214-40-824 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner mines to a conce. 10d. Inside Gity Limits 10a, State 10b. County 10c. City, Town or Location 1 Nes 2 No Director mor 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No 1 Yes Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLE ၉ A AVID Holmon 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 81 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee M. 21213 Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transit The law requires that the death certificate be executed resulting in death) Last of Vital Records, P.O. Box 68760 attending physiciar Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? ò Month Day Year 5 Other (specify) as been signed by the air 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed page 2 □ No 2 🗌 No 1 Yes certificate Physician: 25. Was case referred to medical 26. Place of Death Check on one director Be examiner? 1 ☐ Yes 2 👿 No Other: 4 \( \sum \) Nursing Home 3 🗆 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 X ER/Outpatient ၉ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred the funeral 28b. Time of 27. Manner of Death Certification: Injury Division or Attending Director: After 1 🔀 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No death. 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

completely filled in by fo to.
within 24 hour
the Funeral D'

> rson who completed cause of death (Item 23a) (Type, Print) 32. Registrar's AUG 1 3 2012

and manner stated.

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

State Registrar

29a. Certifier

29b. Signature

(check only one

Medical

DHMH 17 Rev 1/2001 11595

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ August Robert Classen 04 2012 7:40 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 403 Grandin Avenue Rockville Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 375-26-4216 **Director** 1 X M 2 □ F 81 12/19/1930 Michigan Usual Residence of Decedent aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 28a-f 1 X Yes 2 No WV Jefferson Kearneysville 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 55 Garrett Lane 25430 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14 Race - American Indian , or i Completed by Black White etc. 1 Never Married 2 Married 2 No 1948-1 Yes If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Caucasian Year or Dates 1952 other than "naturent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Painter Construction Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked o ည Matthew Classen Millie Franks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Classen Grey - Daughter 403 Grandin Avenue. Rockville, Maryland 20850 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Department of h Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 08/13/2012 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 21. Signature of Funeral Service Licensee M01241 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Interval Between
Onset and Death
2 months Immediate Cause (Final Physician/ Cancer Unknown Primary disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Pregnant at time of death Dav Year signed by the a 4 ☐ Pregnant 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown neec 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? this certificate has performed? Yes 2 X No 2 🗆 No 1 🗌 Yes Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) Daughter's Residence examiner? Hospital 2 🗶 No Other: ဥ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No Accident the Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurs Practitioner: To the be of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29d. Date signed (Month, Day, Year)

State

nd address of person who completed cause of death (Item 23a) (Type, Print)

Nicholas John Farrell,

Date filed (Month, Day, Year) AUG 1 3 2012 D67258

M.D., 9707 Medical Center Drive, #300, Rockville, MD 20850

August 07, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Gwenyth DeWitt Month / 07 / 2012 Year 12:00pM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Brighton Gardens of Tuckerman Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MN **Funeral** 8 Date of Birth Days Hours Min. 1 M 2 XF 566-24-6781 0472844922 **Director** Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Santa Clara Los Gatos CA 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 95030 18400 Overlook Road Unit 63 USA Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Homemaker 2yrs other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည Lewis Wheeler Barbour Beatrice Louise Deakin and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6412 Elmwood Road Chevy Chase MD 20815 Department of Health ar Important: If item 27 is any injury or other trau Charles DeWitt Son 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State cemetery, crematory or other place)
Atlantic Crem 1  $\square$  Burial 2 X Cremation 3  $\square$  Removal from State 8/8/12 Glen Burnie MD 4 Donation 5 Other (Specify) Vuneral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv Sign to Sign ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one of Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exam Cause (Disease or linjury that initiated events resulting in death) Last the burial-trar Iding physician and Physician/Medical P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 month Year Day detached the 9 Unknown signed by it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 D N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (C only one) examiner? Hospital 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural injury 5 Pending work? 2 No after death Accident Investigation the Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one

State Registrar d (Month, Day,

32. Registrar's Signature

se of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ma AVOIDUS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Health & Rehab. Glen Burnie Anne Arundel Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 192-26-9401 1 M 2 X F 79 03/25/1933 South Carolina Usual Residence of Decedent permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Odenton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 490 N. Putuxent Road, #29 21113 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Black. White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Bartacker Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Matthew Bertha Willean Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Munden / Sister 490 N. Putuxent Road, #29, Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 08/13/2012 Anatomy Gifts Registry Hanover, Maryland Signature of Funer Service Licens 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician End-Stare De mentia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) igned by the attending physicien and be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 ☐ Other (specify) Month Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No æ 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 Yes 2 🗌 No 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSKY (YAKZIMD 2835 Smin NV MD 21209

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 3 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8 2012 10 2:40 Medical Name (if not institution, Examiner 4c. County of Death **Funeral** If Under 1 Year 8. Date of Birth 9. Birthplace (State Days Hours 212-54-9926 Month, Day Year — 19—1949 Country) 62 **Director** 1 □ M 2 🕅 MD 28a-f sho 10a State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 ☐ Yes 2 No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 1212 Gilford Road 21060 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 6 Black, White, etc. ş 1 Never Married 2 Married 2 XNo 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes aXX No Specify: white Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72!: th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Bus Aid School System other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Frank Bury Jr. Genevieve Garriot 19a. Informant's Name/Relationship (Type, Print) 1 and 2 shound Health and item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 Gilford Rd Glen Burnie MD 21060 Howard A. Dorsey Jr./spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1: Department of I Important: If it 1 Burial 2 X Cremation 3 Removal from State injury or 8/11/2012 Catonsville MD 4 Domation 5 Other (Specify) Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Frm Arry mais CANDING Medical Due to (or as a consequence of) Examiner 500 803 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or injury PNOUMDNIA that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death ned by the a e detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been sig Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of death? this certificate 2 No Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ٥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 0 Name and address of person who completed cause of death (Item 23a) (Type Print) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 06-2011

Box 68760

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Records,

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Physiciar	R	legistrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	Day Year	3. Time of Death
cal Examin		ta. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deat	August 8, 2	4c. County of Deat	
		21304 Miller's Mill Road Freeland	D Date of Birth	Baltimore Cou	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr  Months Days Hours Mil	_	Forei	ountry) Unck PA
Birector	H	Q18-35-2423 1 1 M M 2 F QO Yrs. Usual Residence of Decedent	I HOLL IS	3,11721	College City Limite
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Aaryland 28a-f show d at once.	<u> </u>	MD Baltimore Freeland  10e. Street and Number  10f. Zip Code	100	g. Citizen of What Cou	
th the Maryland  23a or 28a-f sho notified at once	Director	21304 Miller's Mill Road 21053		USA	
h with 1	ᇹᅡ	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (\$\frac{1}{2}\$ Married   Armed Forces?   13. Was Decedent of Hispanic Origin? (\$\frac{1}{2}\$ tf Yes, specify Cuban, Mexican, Puerly Cuban,		14. Race - Ame White, etc.	rican Indian, Black,
cr deat		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: W	rite
hours af	à þ	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	f work done etired)	16b. Kind of Business	/Industry
136 hin 72 h e. than "n	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)		NIA	
5-00; ed with lygiene other t	ᇙ		ne (First, Middle, M	aiden Surname)	1
21215-0036 and be filed within 7 Mental Hygiene marked other than covert, the Medica	o Be	Kene Hull Dubel  19a, Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of	Rural Route Numb	per, City or Town, Stat	e, Zip Code)
Imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  Lant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor other traumatic event, the Medical Examiner must be notified at once	<b>⊢</b>	Rene H. Duhel-father 21304 miller's M	illRoad	Freeland	1 MD 21053
or Healt of Healt If item		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	
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Physician	1	23a. Part I. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac failure. List only one cause on the cause of the caused the feath.	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
/Medical Examiner	ĺ	Immediate Cause (Final disease or condition resulting in death)  a. Narcotic (Heroin) Intoxication  Due to (or as a consequence of):			
		Sequentially list conditions.			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
ed	Exan	events resulting in death) Last  Due to (or as a consequence of):  d.			
7760, ficate be executed g physician and s the burial - transit	dical	X UNPENDED 23a,27,28a-f,per me,g930 8-27-	-12 sm		
760, icate be physic the bur	/Wec	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg-		23d. Date of delive Month	ery Day Year
Box 68760 e death certificate b the attending physicate of for use as the bu	iciar	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			
). Bo) the death by the att	Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	o the cause of death?
Division of Vital Records, P.O. real or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach	Š		1 Yes		obably 4 V Unknown
ords, w requir	Completed		24a. Was a autop: perfor	sy prior to	autopsy findings available of completion of cause of
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ital Rec sician: The is certificate irector, page	a	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nur		Residence 6 🗸 Ott	ner: Scene
of Vi ing Physi After this uneral di	n: To	1 ✓ Yes 2 No  27. Manner of Death  28a. Date of Injury (Month, Day, Year) (Month, Day, Year) (Month, Day, Year)	28d. Describe h	now injury occurred	
ivision or Attendianter death. Director: /	catio	1 Natural 2 Pending Investigation Restriction Investigation Restriction Investigation Restriction Investigation Restriction Investigation Restriction	28f Location /5	Street and Number or	Rural Route Number, City
DIVIS	Certification:	3 Suicide 6 X Could not be determined (Specify) Residence	or Town, S Freelan	tate)21304 M1	ller's Rd.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a (Check only	and due to the caus ed at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
To th withir To th compl	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (I	
	100	Ce Ci i i i M. O.C.M.E.		August 9, 2012	2
Ø		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimo	re. MD 21223		
-54	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	, = 1220		
Regist					

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		1	For State Registrar	State of Ma	aryıanc		artment of i tificate of i	Health and I Death		gierie Reg. No.	2010	25625
	Physicia		Decedent's Name (First, Middle, Last)	Brenda	s.	Fn	nche		2. Date of Dea		Year	3. Time of Death
50	Medic	al	4a. Facility Name (if not institution, give stre					or Location of Death			2012 County of Death	
mayes	Examin	er	FRANKLIN SQUA		SPITa	1	Re	osedale			3aLTin	
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. las	st birthday)	If Under 1 Year Months Days		8. Date of Birl (Month, Da			hplace (State or Foreign intry)
	Director		Usual Residence of Decedent	1 2 □ <b>X</b> F	62	Yrs.			March 2	25,19	50 Mar	yland
	ryland -f sho ied at	ctor	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits  1 ☐ Yes 2 ☒No
	he Ma or 28a e notif	Funeral Director	Balti 10e. Street and Number	more			10f. Zip Code	Roseda1	e	10g. Citize	en of What Co	
	s 23a nust b	neral	1806 Summit Ave	nue				1237		Uni	ted Sta	ites
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 M Married  3 Widowed 4 Divorced	Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.			Vas Decedent of H f Yes, specify Cub ☐ Yes 2 🕅 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		<ol> <li>Race - Amer Black, White pecify:</li> </ol>	
2-00	hours natura dical E	olete	15. Decedent's Educa (Specify only highest grade)	ation		16a. Deced	lent's Usual Occup	pation during most of work	kina	16b. Kind	d of Business/l	
21215-0036	thin 72 ine. than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	life. D	O NOT use retired,		ung	N.		
	iled wit I Hygie other ent, th	Be	12 Years 17. Father's Name (First, Middle, Last)	Year		sec	eretary	18. Mother's Nan	ne (First, Middle,		edical urname)	
ylan	ld be fi Menta arked atic ev	입	James H. Shuma					Doris	J. Jacl	kson		
Maryland	2 shou th and traum		19a. Informant's Name/Relationship (Type, Mr. Michael N. Emch		and			and Number or Rui				
	if Heali item 2 other		20a. Method of Disposition			ace of Dispo	sition (Name of	Avenue	Roseda Le		ation - City or	21237 Town, State
Baltimore,	Page ment o ant: If ury or		1 Burial 2 XCremation 3 Report Donation 5 Other (Specify)	moval from State	Hi]	metery, cren Lltop	natory or other pla Service	Corp. 8/	13/2012	Tows	son, Ma	ryland
Balt	Depart Import any inj		21. Sign ture of Funeral Service License 6	ennis C.	Sacr	011 22 L	Name and Address uda-Ruck	ess of Facility Funeral e Aye. Du	Home of	Duno Maryl	dalk, I	nc. 1222
	Physician ) Medical Examiner	ner	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading the short of the	tions that caused ause on each line  Sep  Due to (or as	S I S a conseque	Do not ente					,	Approximate Interval Between Onset and Death 2 w <
8760 0978	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as								
. Box 68760	Attending Physician: The law requires that the death certificate be ir death. sctor: After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the bu		23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	If yes, outcome    Live Birth   Live Birth	2 Fetal	death 3	Ectopic pregnar Other (specify)	псу		20	3d. Date of del Month	ivery Day Year
ls, P.O.	uires that the n signed by uld be deta	ed by PI	Part II. Other significant conditions contrib	outing to death b				iven in Part I.				the cause of death?
Division of Vital Records,	The law req ate has bee page 2 sho	Somplet	Chronic R Anemia	enal	7	ailu	1-2		24a. Was auto perfo 1 \(\sum \text{Yes}\)		prior to death?	topsy findings available completion of cause of
ital	ician: certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	pital:			Total	Place of Death (Chec				
n of V	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	cate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	1 Inpati 28a. Date of inju (Month, Da	iry 2	ER/Outpatier 28b. Time of injury	28c, Inju	4 □ Nursing F iry at	ome 5 Resi			ify)
Divisio	tal or Atter rs after dea al Director ed in by th	Medical Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injusting, etc.			eet, factory, office		28f. Location (S City or Tov		Number or Rui	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medica	only one) 3 Certifying Nurse F	On the basis of e	xamination	and/or inves	tigation, in my opin , death occurred at	ion, death occurred the time, date and p	at the time, date a	and place, a the cause(s	and due to the o	cause(s) and manner stated. s stated.
	To Vait		29b. Signature and title of certifier	2 00			29c. Licens	t005599	Z	1	signed (Month 08/12	i, way, rear)
	V		30. Name and address of person who com  Debovon L. Gallo De	pleted cause of c	leath (Item :	23a) (Type, F	Print) Ave B	t005599	MP	2122		
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 3 2012	32. Regist	ar's Signatu	ire						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 28a-f per me g930 8-13-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Month 3:00 A M 2 Arlette Fumiere August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4982 Sentinel Drive # 204 Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Hours Min Country 578-17-7811 1 □ M 2 🛛 F 52 Yrs February 16, 1960 Belgium Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 4982 Sentinel Drive # 204 20816 Belgium 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, White, etc. Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Learning Analyst Finance 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Spetebroot Ferdinand Fumiere 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas Flanders / Husband 4982 Sentinel Drive # 204, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of August 7, 20c. Location - City or Town, State Montgomery Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bethesda, Maryland Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Physician) Medical **Examiner** Examine Physician/Medical

Physician/

Medical

Director

Funeral

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**Examiner** 

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permit. Page 1 and 2 should be filed within 7. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment.

hours after death

Baltimore, Maryland 21215-0036

injury or other traumatic event, the Medical Examiner must be notified at

physician s the burial attending |

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Completed

Certificate: To Be

Medical

29b. Signature and title of certifier

Betsy 31. Date filed (Month 1601

Ballard,

DME

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IF

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ed by the a page 2 s To the Hospital or Attending Physician: 

04

State Registrar

mmediate Cause (Final			Onset and Death
esulting in death)	a. Due to (or as a conse of no):		
Sequentially list conditions, f any, leading to immediate cause. Enter Underlying cause (Disease or Injury	b. Due to (or as a consequence of):		
hat initiated events assume that initiated events assume that the second in the second	C. Due to (or as a consequence of):  d.		
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of delivery Month Day Year
art II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
degression		1 ☐ Yes	2 No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed?	
5. Was case referred to medical	26. Place of Death (Che	eck only one)	
examiner? 1 Yes 2 No	Hospital:  1	Home 5 Residence	6 Other (Specify)
7. Manner of Death	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?	28d. Describe how inju	ury occurred
1 ☐ Natural 5 ☐ Pending 2 ☐ AccidentInvestigati	on <b>fd. 8–2–12 unknown</b> M 1 Yes 2 No	subject ha	nged self
3 Suicide 6 ☐ Could not 4 Homicide determine		28f. Location (Street a City or Town, Sta #204 Bethe	and Number or Rural Route Number, te) 4982 Sentinel Dr.
	sysician: To the best of my knowledge, death occurred at the time, date and place		

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29018

10301 Georgia Avenue, Silver Spring, Maryland 20902

29d. Date signed (Month, Day, Year)

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Catherine Fornataro 1 Pay Aug 2012 7:35P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carrol1 Sun Valley Assited Living Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min (Month, Day, Year) 078-16-7873 Director 1 □ M 2 🖾 F 100 7/25/1912 New York Usual Residence of Decedent item 27 is marked other then "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits filed within 72 hours after death with the Mayland al Hygiene. d other then "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director MD Carrol1 1 Yes 2X No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4201 Navajo Dr. 21157 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: White 3 ₭ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laundry and Dry Cleaners Kay's Cleaners 12th Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Importent: If item 27 is marked oth eny Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Lucy Scaravion Frank Giradino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4201 Navajo Dr. Westminster, MD 21157 19a: Informant's Name/Relationship (Type, Print) James M. Fornataro (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carroll Crematory 8/13/2012 Winfield, MD Signature of Euperal 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory,
1212 W. Old Liberty Rd. Winfield, MD 2178 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Heast failule Immediate Cause (Final Svitzsproj Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): signed by the attending physician and debached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 1 Yes 2 16 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ( whollower 1 Yes 2 No 3 Probably 4 Unknown To the Funeral Director: After this certificate hes been si completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 N Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatl 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the only one 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) unsul GIMY) D 51705

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Box 68760

P.O.

State Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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West mirster, MD 21157

Please Type or Printing lack/Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ann Ferracci August 2012 8:32  $\mathbf{P}^{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 253\_S. Central Avenue Baltimore 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 1 □ M 2 🖾 F 75 10-26-36 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Baltimore MD 1 X Yes 2 No or. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 21202 253 S. Central Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces ģ ☐ Yes 2 🛛 No ò 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Specify: White If Yes, Give "natural", 3 X Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Margaret Marino John Santacroce other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 253 S. Central Avenue Balto. Md. 21202 John A. Feracci - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State West Arundel Crem. 8-15-12 Odenton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. 21. Signatur 21224 Conkling St. Baltimore, Md. 23a. Part 1. Enter to cisea ea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate ause (Fin-Onset and Death Ph\_sician/ Congestive Heart Failure disea r condition Medical Examiner Hypertension Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 phys the b as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🔀 No Day Year Pregnant at time of death the a 9 | Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Chronic Obstructive Lung Disease Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page performe certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: 2 💢 No 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 4 Nursing Home 5 X Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completely filled in by the funer (Month, Day, Year) 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only of 29b. Signatur 29d. Date signed (Month, Day, Year) D006015 8-13-2012 who completed cause of death (Item 23a) (Type, Print) Rosalyn Stewart, Caroline St. Suite 7143 Balto. M.D. 601 N.

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Date Month 3. Time of Death Physician/ Rebecca Drew Fitzsimmons 300 M 70/1 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Annapolis Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2V Director 236-04-8410 44 1967 Virginia Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c City Town or Location 10d. Inside City Limits Director 1 Ves 2 No Marvland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral USA 2106 Bay Drive 21409 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) e 1 and 2 should be filed within 72 I t of Health and Mental Hygiene. If item 27 is marked other than "r or other traumatic event, the Med Elementary/Seconday (0-12) 2 College (1-4 or 5+) Office Manager Air Craft Indust. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sara Titlow Daniel G. Drew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2106 Bay Drive, Annapolis, Maryland 21409 Department of Health Important: If item 27 any injury or other trong once. Mark E. Fitzsimmons - Husband 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Page ' Meadowridge Mem. Park 08/10/12 Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 21. Signature of Finera Service License M01283 7250 Washington Blvd., Elkridge, MD 21075 r caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease or complications to shock, or heart failure. Ust only one cause on Interval Between Immediate Cause (Final BRAIN Onset and Death Ph. sician/ DEATH disease or condition 09:1 Medical resulting in death) Due to (or as a consequence of **Examiner** CARDIAC ARRES DATI Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the control of the cont the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No be detached for Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CARDIOMYOPATITY 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should ESRI 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? DM Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident work?
1 Yes 5 Pending 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

30. Name and address of person who completed

31. Date filed (Month, Day,

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Medi

cause of death (Item 23a) (Type, Print)

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Evangeline Y. Frangos

State of Maryland / Department of Health and Mental Hygiene

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1- For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Time of Death 2. Date of Death Physician/ Year 1512 hrs al Examiner August 8, 2012 Evangeline Frangos 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Franklin Square Hospital Rosedale If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Foreign Hours Director 215-52-2679 11/05/1946 country Maryland 65 2 XX 1 M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location r 28a-f show 1 Yes 2 No MD Baltimore Rosedale Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1 Weyburn Court 21237 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married Yes 2 X No White 3 Widowed If Yes. Give Year 1 Yes 2 X No specify: Specify: <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specity only highest grade completed) Completed during most of working life. DD NDT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore**, MD 21215-0036 Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Triffon George Alatzas Markella Tangires 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21104 MD Markella Sando-daughter <u> 936 Victory Hills Way, Marriottsville</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State permit. Page:
Department o
Important: | St. Demetrios 8/13/12 Cub Hill, MD Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee William G. Ruck Towson Funeral Home, Inc. Dau <u>1050 York Rd.</u> MD Towson. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hysician Between Onset and failure. List only one cause on each line. /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physiclan/Medical AMENDED 23a, pt. II, 27, per me, g930 8-16-12 sm X UNPENDED the attending physician ed for use as the burial -Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year 1 Live birth Fetal death Month Day past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Yes 2 No 3 Probably 4 Unknown perforated rectal carcinoma with associated pelvic Completed 24a. Was an 24b. Were autopsy findings available abscess autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director; 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Wedical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. August 9, 2012 and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 **OCME** 31. Date filed (Month, Day, Year) Registrar

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a B	ician: The certificate rector, pag	Be Co	25. Was case referred to medical				2	6. Place of Death	(Check only o		X No	1 ∐ Yes	2 L No
Vita	Physicia this cert al direct	To B	examiner? 1 Yes 2 X No		patient 2 🗆 E			Other: 4 🗌 Nur	sing Home 5	Residen	nce 6 Othe	er (Specify	)
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Division of Vital Records,	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certificate:	2	28e. Place o	f Injury - At hor , etc. (Specify)	me, farm, str			28f. Lo	ocation (Stre ity or Town,		er or Rura	Route Number,
The state of the s						ne, date and	place, and due	e to the ca	use(s) and manner stated.				
	To the within 2 To the comple		29b. Signature and title of certifier	, A.			29c. Lic	cense number	95	29	d. Date signed		Day, Year) 2012
	. ^		30, Name and address of person who	completed cause	of death (Item	23a) (Tvne	Print)	000031	7.3			J. U.7	, 2012
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AUGUST 201 ll:45A<sup>™</sup> 8 Medical 4c. County of Death
BALTIMORE 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death TOWSON SAINT JOSEPH MEDICAL CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 262-14-802 1 M 2 □ F **Director** 96 or 28a-f shov 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10b. Count 10c. City, Town or Location with the Maryland Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21161 9020 acı 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married 1 Yes 2 No Specify. "natural", 3 Widowed 4 ☐ Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working laryland 2121 and Mental Hygiene.

is marked other than life. DO NOT use retired) filed within Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the 12 Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam ည pe 1 and 2 should b Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rout ber, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Monkfordo 21111 Signature of Funeral Service 22. Name and Adress of Facility 16924 Kd. Monkton 23a. Part 1. Enter the dise shock, or heart failure r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each life. Approximate Interval Between CARDIAC ARREST Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ARRYTHMIA Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or). The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 □ Yes 2 █ No Month Day Year Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown RECENT HIP SURGERY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No Director: After this certificate To the Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗙 No မ 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: Natural 5 Pending work? 2 🗆 No Investigation 6 Could not be Accident filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

10x1 Ex

31. Date filed (Mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NEAL FRANKEL, D.O.

7601 OSLER DRIVE TOWSON, MD 21204

12-05937

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physician	1/	Decedent's Name (First, Middle,Last)	Ella Grace Ann	Garrison	2. Date of Month	of Death Day	Year	3. Time of Death
Medical Examin	er	Ellagre	ce Ann C	arrison		st 8, 2012	c. County of Death	1337 hrs
		4a. Facility Name (if not institution, give s Franklin Square Hospital	treet and number)	4b. City, Town, or Loc Rosedale	cation of Death		Baltimore Cou	nty
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ID 21215-0036 should be filed within 1 and Mental Hygiene. 7 is marked other that natic event, the Medica	ا د ه	17. Father's Name (First, Middle, Last)  Richard V	Vayne Garr		Heather			rett
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Baltimore, Mi permit Pages I and 2 to Department of Health a Important: Uf item 2/1 injury or other traum	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	Crema	22. Name and Address of Evons Fune	Facility Class COLE	1 1 to	cest Itill	Maniford
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Physician // // // // // // // // // // // // //		23a. Part l. Enter the disease, or complication failure. List only one cause on each	line.		ch as cardiac or respirato	ry arrest, sh	ock, or heart	Approximate Interval Between Onset and Death
Examiner	ļ		omplications of e to (or as a consequence of):	Prematurity				Death
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lox 6876 leath certificate e attending phy for use as the it		past 12 months?	Prognant at time of death	Fetal death 3 U	Ectopic pregnancy	ļ	Month Da	ay Year
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P.O.	2	Part II. Other significant conditions co	ntributing to death but not resultin	g in the underlying cause give	_		use contribute to the	bly 4 Unknown
ords, P	Completed					Was an		ppsy findings available
of Vital Records, ng Physician: The law requir ther this certificate has been si meral director, page 2 should b	E					autopsy performed? Yes 2 N	death?	mpletion of cause of
ital Recions: The sectificate rector, page		25. Was case referred to medical examiner?			Death (Check only one)			
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Division pital or Attendio ours after death. filled in by the fu	8	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, fa	arm, street, factory, office build			and Number or Rura	al Route Number, City
Divisior  Hospital or Attend 24 hours after death : Funeral Director: stely filled in by the	5   5  -	4 Homicide determined	(Specify)		or ic	wn, State)		<u>, , , , , , , , , , , , , , , , , , , </u>
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitived Certification:	2	one) 2 Medical Examiner: Or	To the best of my knowledge, de the basis of examination and/or i					
To wit	Ē	29b. Signature and title of certifier	d manner stated.	29c. License nu	umber	29d.	Date signed (Mont	h, Day, Year)
W. L		Carac He	allan	O.C.M.E	<b>.</b>	Aug	gust 9, 2012	
Johnson		30. Name and address of person who com Carol H. Allan, MD Assista	pleted cause of death (Item 23a) ant Medical Examiner 90	00 W. Baltimore Street,	Baltimore, MD 212	223		
Stat	е	31. Date filed (Month, Day, Year) AUG 1 3 2012	32. Registrar's Signature	uked				
Registra	Ш	AUG 1 3 2012	Color 12		<del></del>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr 2930 8-13-12 vt State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ 3:56 <u>JEANNE</u> GODLEY-DAVIS CLAIRE Medical 4a. Facility Name (Fnot institution, give street and number) Town, or Location of Death 4c. County of Death Examiner N/A9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Hours Min Country) Director 230-70-0445 1 🗆 M 2 🗶 F 65 08/04/1947 VA Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho Director 1 Tyes 2 X No CATONSVILLE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 21228 USA 106 SMITHWOOD AVENUE permit. Page 1 and 2 should be filed within 72 hours after death of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other fraumatic event, the Medical Examiner mi 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5⊹ EDUCATION ENGLISH TEACHER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ MOOMAW, III **JEANNE** C BENJAMIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 106 SMITHWOOD AVENUE, CATONSVILLE, MD Department of Health Important: If item 27 any injury or other the once. ALBERT GODLEY-DAVIS/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other p ANSHE EMUNAH CHAIM CEMETER 20c. Location - City or Town, State 20a. Method of Disposition ematory or other place)
EMUNAH AITZ
CEMETERY 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 08/10/2012 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL, LEVINSON & BROS., INC. Mast Ce 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): physician Physician/Medical écolds, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 monti Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Onknown Certificate: To Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) Other: Dies R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical

Registrar DHMH 17 Rev 06-2011

State

29a. Certifier

(Check 29b. Signature and

30. Name and add

31. Date filed (Month

s of person who completed cause of death (Item 23a) (Type, Print)

Jehangir Meer

3 2012

Day, Year)

AUG 1

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

900 S. Caton Avenue Baltimore, Md. 21229

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Ann Hayden  $A_{M}$ August 12, 8:30 20 Lea Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Tranquillity At Fredericktowne Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Columb : Funeral 8. Date of Birth (Month, Day, Year) Days Min 216-38-5640 Columbia Director 1 □ M 2 F 91 Nov 1, 1919 Distict of Usual Residence of Decedent item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21703 6441 Jefferson Pike United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4 or 5+) Social Worker Montgomery County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 end 2 should be file Department of Health and Mental I-Important: If item 27 is marked or any Injury or other traumatic ever James Donahue Hazel Arnette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Wilson Rd. Crownsville, MD 21032 Edward Delaplaine (executor) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🖾 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Carroll Crematory 8/14/2012 Winfield, MD Signature of Functions Service Licens 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 2178 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hertersin Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or a a consequence of) Examir To the Hospital or Attending Physician: The law requires that the deam cerumate be expected within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Ounknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ၉ 1 ☐ Yes 2 PNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Anatural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 7-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Court Hagerstown, MD 21740 M. Khalid Waseem, MD, CMD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

AUG 1

Box 68760

P.0.

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Zabiullah Ali, M.D.

31. Date filed (Month, Day Year)

900 W. Baltimore Street, Baltimore, MD 21223

Assistant Medical Examiner

32. Registrar's Signatur

10d. Inside City Limits 1 Yes 2 X No 22 Name and Address of Facility Gary L. Kaufman Funeral Home at Approximate Interval Between Onset and 1 Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1800 Candle Light Court 1800 candle light court, Owings, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ga 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 1, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Hershey, Sr. 12:15 PM Ronald Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min. (Month, Day, Year) Director 212-26-9298 1 🛛 M 2 🗆 F Yrs. Dec. 20,1930 Maryland 81 show 10a. State 10b. County r then "netural", or Items 23a or 28e-f sho the Medical Examiner π ust be notified at 10c. City, Town or Location 72 hours after death with the Maryland Director 10d. Inside City Limits MD Baltimore 1 Yes 2 No Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 2716 Apt. Dunbrook Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Mamied 2 Mamied Baltimore, Maryland 21215-0036 <u>&</u> If Yes, Give Year or Dates 1 ☐ Yes 2 🖸 No Specify. 3 XWidowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Anchor Motor Co. <u> 3 Years</u> is marked other Be 17. Father's Name (First, Middle, Last) it. Page 1 and 2 should be filed intment of Health and Mental H intent. If item 27 is marked ot njury or other treumetic ever 18. Mother's Name (First, Middle, Maiden Surname) 2 Effie Cornwall Alvin Hershey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1362 Wiley Oak Drive Jarrettsville, MD Mrs. Kimberly A. Hershey-Ries 21084 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Depertment of I
Importent: If it
eny Injury or o
once. 1 🖺 Burial 2 🗌 Cremation 3 🔲 Removal from State 8/11/2012 4 Donation 5 Other (Specify) Oak Lawn Cemetery Baltimore, Maryland Funeral Service Licensee Gregiry Reed Buda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physicien: The law requires that the death certificate be executed 24 hours after death.

Funerel Director After this certificate has been almost booth to the continue of the continue use as the burlal-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year To the Funeral Director. After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performi 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No å 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending work?
1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and le of certifier 29c. License number 29d. Date signed (Month, Day, Year) 400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DShaheeu, 67014.

Registrar

31. Date filed (Month, Day, Year)
AUG 1 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 20 Y 2 2:20 P<sub>M</sub> Norman L. Hendricks Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11 W. 20th St; Apt 15H Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 24 Hrs. **Funeral** . Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours 216-54-4224 Director **X** M 2 □ F 62 Sept.19,1949 MD Usual Residence of Deceden 10a. State 10h Counts 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified 28a-f MD Baltimore 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Funeral 11 W. 20th St. Apt. 15th Flr 21218 USA death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces ь þ X☐ Never Married 2☐ Married 1 Yes 2 No Army 1 Yes 2 No Specify "natural" Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12th Baltimore City ath and Mental Hygie 27 is marked other r traumatic event, th Sanitation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leroy Hendricks Queen Mayo 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1010 W. Baltimore St. Balto, Md. Alfreda Spruill (sister) f Health a 21223 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot once. Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State OwingsMills Medical **Examiner** 

Physician/

Baltimore, Maryland 21215-0036

physician Be Completed by Physician/Medical signed by has To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

Division of Vital Records, P.O. Box 68760

	4 ☐ Donation 5 ☐ Other (Specify)	GarrisonForestVetCemAug 13, 2012						
	21. Signature of Funeral Service Licenses		22. Name and Address of Facility			01010		
		2	Calvin B. Scruc 1412 E. Prestor	ggs Funera	ıl Home <sub>B</sub>	212 <u>1</u> 3 Balto,Md		
	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death. Do not	t enter the mode of dying, such as cardia	c or respiratory arrest,		Approximate		
	Immediate Cause (Final disease or condition	DISFASE	Unterval Between Onset and Death					
	resulting in death)	Due to (or as a consequence of):		1307.00				
		Archiotoc 1	MODOTALS					
	Sequentially list conditions, b if any, leading to immediate	Due to (or as a consequence of):	):					
	cause. Enter Underlying Cause (Disease or injury							
i	that initiated events c. resulting in death) Last	Due to (or as a consequence of):	):					
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	IF FEMALE: 23b. Was decedent pregnant 23	23d. Date of deliv	e of delivery					
	in the past 12 months?  1							
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	Part II. Other significant conditions conf	iributing to death but not resulting in the	23e. Did tobacco	he cause of death?				
3	Hypertension) 1 yes 2 No 3 Probably 4 Punkno							
	Alcohol Abi	164		24a. Was an 24b. Were autopsy findings available				
	autopsy performed?							
	25. Was case referred to medical		26. Place of Death (Chr	1 Yes 2		2 No		
í								
	1 12 Yes 2 No	spital: 1						
	1 Natural 5 Pending	28a. Date of injury (Month, Day, Year) 28b. Timinju	ury work?	28d. Describe how inju	8d. Describe how injury occurred			
)	2 Accident Investigation 3 Suicide 6 Could not be		M 1 Tyes 2 No					
	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	ce of Injury - At home, farm, street, factory, office ding, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	only one) 3 L Certifying Nurse	Practitioner: To the best of my knowled	edge, death occurred at the time, date and	place, and due to the caus	se(s) and manner as	stated.		
	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month,	Day, Year)		
	Yada K	wow. M.I	D. 10004079	5	89112			

VA. MED, CTR. 10 NOVYUGARRAN STV. BALT., MD. 2120)

State Registrar address of person who completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Everline Hoshall August 12:15pm<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Long View Hursing Home Manchester Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Min (Month, Day, Year) Director 212-36-2095 1 □ M 2X□ F 90 Sept. 17,1921 MD Usual Residence of Decedent 28a-f shov 10h County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 ☐ Yes 2XX No MD Carroll Sykesville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe items 23a on the second records in the second records it is not the second Funeral Village 21784 7426 Road United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Tes 2 No Specify: "natural", Specify: White Completed 3XXWidowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H 7 is marked of ပ္ John Harris Everline Elizabeth Fowler other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 Dennis Hoshall 2525 Baltimore Blvd. Finksburg, MD 21048 (son) 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important; If ite any injury or oth Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 8-15-2012 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gar. Finksburg, MD Signature of Funeral Service Licensee 22. Name and Address of Facility ELINE FUNERAL HOME X a ken 11824 Reisterstown Rd. Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ monar disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte Month Dav Year Pregnant at time of death 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💓 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director; After Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, To the ! Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 06051705

324

DHMH 17 Rev 06-2011

State Registrar 349 Malcolm Dr Westminster MD

on who completed cause of death (Item 23a) (Type, Print)

ansuriua

WD

12-05954 Deirdre Diana Huddles

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 25641

	1- For State Registrar		Certificate of	Death			g. No.	10 Time (0 m		
Physician/ Cal Examiner	Decedent's Name (First, Midd)	Decedent's Name (First, Middle,Last)			Date of Death Month Day Year August 8, 2012  3. Time of Death 2114 hrs					
	4a. Facility Name (if not institution	o. City, Town, or Lo Cockeysville	City, Town, or Location of Death			4c, County of Death  Baltimore County				
		Falls Road north of Gadd Road  5 Social Security Number			If Under 24Hrs.					
Funeral Director	5. Social Security Number 214-84-9616		59 Yrs.	Months Days	Hours Min.	Aug.	8,1943 F	Country)Sri Lank		
ķt.	Usual Residence of Decedent 10a, State 10b. County	10c.	City, Town or Location	n				10d. Inside City Limits		
low any						1 Yes 2 No				
the Maryland t or 28a-f show tified at once.  Director	10e. Street and Number		10f. Zip Code 10g			g. Citizen of What	. Citizen of What Country?			
the Maritine of 2 infeed in Dire	8 Fiske Avenue 211									
death with the Maryland or items 23s or 28s-f shomust be notified at once.	11, Marital Status	in U.S. 13. Was	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>			- 14. Race - A White, e	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>			
or items 23	1 Never Married 2 N	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 N Divorced If Yes, Give Year			1 Yes 2 No specify:			<sub>Specify:</sub> White		
rainer by	3 Widowed 4 ZYDI	d) 16a, Decedent	1 Yes 24141No specify:  Sa. Decedent's Usual Occupation (Give kind of work d			ork done 16b. Kind of Business/Industry				
2 hour last last last last last last last last	Elementary/Secondary (0-12)		College (1-4 or 5+)  Do al Ectat		OO NOT use retir	ed)	Prude	Prudential		
5-0036 ed within 72 hours bygiene. other than "natu the Medical Exam Completed	12	5+	Real			(Pint Baidelin I	Asidon Cursomo)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once TO Be Completed by Funeral Director						ra (un	First, Middle, Maiden Surname) ca (unknown) Hunt			
212 ould b ould b d Ment s marl fic eve	19a, Informant's Name/Relation						nber, City or Town,			
MD d 2 sho lith and m 27 is	Michael P. H		/5 W 20b. Place of Disposi			Date Ne	20c, Location - Ci	NY 10005 ty or Town, State		
ore, es l an of Hez If ite	20a Method of Disposition  1 Burial 2 Cremation	n 3 Removal from State	Evamaso Fut	neral c	haplel	/12/12	Forest	п:11 MD		
Baltimore, permit. Pages l a Department of He Important: If ite	4 Donation 5 Other S 21. Signature of Funeral Service	pecity.	& Cremat				tion Se	Hill, MD		
Bal Depar Impo injur	taci	2 Spal	(λ 116	924 Yor	k Road	. Monk	ton, MD	2 11 11		
Physician	23a. Part I. Enter the disease, of	or complications that caused the content on each line.	death. Do not enter th	e mode of dying, s	uch as cardiac o	r respiratory arr	est, shock, or heart	Dottioon onter and		
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuries									
	or condition resulting in death)	Due to (or as a consequent	nce of):							
Į.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
ted nisit	cause. Enter Uniterlying cause (C) (Disease or injury that initiated events resulting in death). Last United Company (C) (Disease or injury that initiated events resulting in death). Last (C) (Disease or injury that initiated events resulting in death).									
760, icate be executed physician and the burial - transit		d								
760, cate be executed physician and he bunial - transi	UNPENDED	AMENDED					23d. Date of de	alivery		
8760, tificate be ng physic as the buring		, Live on an	2 Fe	tal death 3	Ectopic pregna	ancy	Month	Day Year		
Box 68 e death certif the attending ted for use as	2 Fetal death 3 Ectopic pregnant of the past 12 months?  1 Ves 2 V No 9 Unknown  1 Live birth 2 Fetal death 3 Ectopic pregnant of the past 12 months?  5 Other (Specify)  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Records, P.O. Box 68. The law requires that the death certificate has been signed by the attending page 2 should be detached for use as incompleted by Dhysician	Part II. Other significant cond	litions contributing to death but	not resulting in the u	ınderlying cause gi	iven in Part I.			te to the cause of death?		
P.C es that es that be detected by	1 Yes 2 No 3 Probab									
Records, I The law requires ficate has been significate has been significate has been significate has been significant of the first page 2 should be formal of the formal of the first page 2 should be formal of the first page 3 should be formal of the first page 4 should be formal of the first page 5 should be formal of the first page 6 should						24a. Was auto	psy pri	ere autopsy findings available or to completion of cause of		
eco he law ate has								ath? Yes 2 No		
cian: 1	25. Was case referred to medic examiner?				of Death (Check		Residence 6	Othor: Scene		
Physic ruthis or all direction		Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatient	3 Box	y at Work?	28d. Describe	how injury occurred			
ading l		(Month, Day Year) Aug 8, 2012	2102 hrs		'es 2 ✔ No	Driver auto	auto collision			
Division of Vital Records, P.O. hopital or Attending Physician: The law requires that the neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact or discontinuation. To Do Commission by the processing of	2 ✓ Accident Inv 3 ☐ Suicide 6 ☐ Co	ould not be	- At home, farm, stre		uilding, etc.	or Town	State)	or Rural Route Number, City		
hou hou	4 Homicide determined (Specify) Major Road / Highway Falls Road north or Gadd Road, Cockeysville, MD Palls Road north or Gadd Road, Cockeysville, MD Falls Road north or Gadd									
To the Ho within 24 To the Fu	one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
F. 2 F. 8	29b. Signature and title of cert		A	29c. Licens				d (Month, Day, Year)		
15 NV (2(1 p l 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2										
12%	30. Name and address of sers Zabiullah Ali, M.D.	on who completed cause of death Assistant Medical Exam		Baltimore Stre	et, Baltimore	, <b>M</b> D 21223				
Sta Registra	/\	32. Registrar's S	Signature S. Sark	,						
DHMH 17 Rev 1/200	, , , , , , , , , , , , , , , , , , , ,	James -	ORIGINA				001	WE .		

Please Type or Print in Black Indelibled nk/ Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 20T2 1:55 Ам Peter Igwilo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Montgomery Casey House Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Days Hours Min. Jan 11 Day, Year 64 WTYeria Director 215-21-9782 48 1 ₺ M 2 🗆 F Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at within 72 hours after death with the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Takoma Park Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 **IISA** 641 Houston Avenue; Apt 206 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc δ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 Specify: black 1 Yes 2 No Specify. 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " College (1-4 or 5+) Elementary/Secondary (0-12) healthcare nurse Be permit. Page 1 and 2 should be filed Department of Heath and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ladi Adele Edoja Igwilo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1220 Minnesota Ave; Columbus, OH 43211 Paul Igwilo - brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Funeral Service Licensee 21. Signaturu Ronald S . Wade 655 W. Baltimore St; Baltimore, MD 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ malignant neoplasm of esophagus disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Completed 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy
performed?
Yes 2 12 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other:  $_4$   $\square$  Nursing Home 5  $\square$  Residence 6  $\boxtimes$  Other (Specify) hospice 1 ☐ Yes 2 🔯 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature e of certifie 29c. License number 29d. Date signed (Month, Day, Year) D37142 8/22/2012 ss of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd; Rockville, MD 20855 Coleman 31. Date filed (Month, Day, Year) Registrar's Signature State **AUG 13** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Year Month Wallace Omsby Irish Medical 08/07 2012 12:38 n 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Greater Baltimore Medical Center <u>Baltimore</u> If Under 7. Age (In yrs, last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 092-38-0674 **Director** 1 XM 2 □ F Mar. 16, 1929 83 Trinidad Usual Residence of Decedent 3a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Baltimore Pikesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a event, the Medical Examiner must b Funeral 3320 Smith Avenue 21208 USA death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ģ 1 Never Married 2 XMarried within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 NYC Fire Dept. Accountant Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Rupert Irish Stella McCarthy and 2 should be Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3320 Smith Avenue; Pikesville, MD 21208 Cynthia T. Irish wife permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t 20a. Method of Disposition
1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation Other (Specify) Druid Ridge Cemetery 8/13/2012 Pikesville, MD Signature of Fu e al Service Scens 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Towson, MD 21204 Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death hysician/ disease or condition Renal failure over mont Medical resulting in death) Due to (or as a consequence of) **Examiner** Diabetes and numerous renal cysts Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury vears Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Contact at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebal edema 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? performed? 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 No Other: ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral to Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

State Registrar

2 Accident

4 Homicide

29a. Certifier

Suicide

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation

determined

8 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c, License numbe

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D38352

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

08/08/2012

Charles Street, Baltimore, 21204

Beth R. Schwartz, 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 3 2012

12-05908 Derrick Jenkins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

errick Jenkins	1- For State	of Maryland / Departi <i>Certif</i>	ment of Health ar icate of Death	ia Mentai Hyg		No. 201	2 2561	
Physician/	1. Decedent's Name (First, Middle,La	st)		2.	Reg. Date of Death Month D	ay Year	3. Time of Death	
fedical Examine	DERLICK JENKINS  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death				August 2, 20	12 4c. County of Deat	1438 hrs	
	Johns Hopkins Bayview Medical Center  Baltimore							
Funeral Director	5. Social Security Number 6. S 212-82-9011	Fex 7. Age (In yrs, last)	oirthday) If Under 1 Yea  Months Day		8. Date of Birth()	Forei	thplace (State or gn Duntry) MD	
ıny	Usual Residence of Decedent 10a, State 10b, County	10c. City, Too	wn or Location				10d. Inside City Limits	
and show a	MD	Balt	timore				1 Yes 2 No	
the Maryland or 28s-f sh tified at one Director	10e. Street and Number 10f. Zip Code 21213			-		Citizen of What Cou	ntry?	
s 23a o	11. Marital Status	12. Was Decedent Ever in U.S.	2/2/3 13. Was Decedent of Hi			USA 14. Race - Amer	ican Indian, Black,	
er death v , or item r must b	1 Never Married 2 Marrie	A-mad Farance		n, Mexican, Puerto Rio		White, etc.	ack	
atural"	15 Decedent's Education (Crossify)	or Dates:	a. Decedent's Usual Occupa	tion (Give kind of world		bb. Kind of Business/		
5-0036 led within 72 hour Hygiene. the Medical Exar	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life  LandSCap		,	PRIVA	te	
21, be fill mtal F rked ent, 1	17. Father's Name (First, Middle, Las Harry J. Jen 19a. Informa Name/Relationship (	· ·	19b. Mailing Address (Stree	18. Mother's Name (Fi				
MD 21 d 2 should d 2 should lth and Mer n 27 is mar n 17 is mar	Dorothy L. Jenk							
	20a. Method of Disposition  1 Burial 2 Cremation 3	20b. Plac	3413 Dudle e of Disposition (Name of ce natory or other place)	* 1	1			
Page ent c	4 Dopation 5 Other Specify	Mor	eland Ceme 22. Name and Addres	tery 8/11	112	Baltimo	ire, Md	
Balti permit. Departm Importa injury o	21. Signature of Fundat Service Lice  23a. Park. Enter the disease, or com	nsee 9/353	22. Name and Addres	K Road.	BAL ti	MAYE M	ERAL SUS	
Physician	23a. Part. Enter the disease, or comfailure. List only one cause on e	plications that caused the death. Do ach line.	not enter the mode of dying,	such as cardiac or re	spiratory arrest,	shock, or heart	Approximate Interval Between Onset and	
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Complications of Due to (or as a consequence of):	Metastatic Ca	rcinoma of	the Col	on	Death	
	Sequentially list conditions, b				<del></del>			
ed nsit <b>Examiner</b>	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							
uted Id ansit	events resulting in death) Last	Due to (or as a consequence of):						
obe execute by the control of the co	□ AMENDED 23a,27,per me,g930 8-29-12 sm							
876C tificate on physical by the bull by t	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnand	cy 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery	) Day Year	
). Box 68760, the death certificate be by the attending physic ched for use as the bun Physician/Med	past 12 months?  1 Yes 2 No 9 Unknow	Pregnant at time of death	5 Other (Specify)					
P.O. B s that the degned by the e detached i	Part II. Other significant conditions		ing in the underlying cause o	given in Part I.		cco use contribute to		
IS, P.C quires that en signed ald be deta					1 Yes 2		topsy findings available	
of Vital Records, as Physician: The law require the this certificate has been signeral director, page 2 should be 1. To Be Completed	-			<del></del>	autopsy performe	prior to death?	completion of cause of	
tal Relician: The certificate rector, page	25. Was case referred to medical			of Death (Check only	1 Yes 2 one)	No 1 Y	s 2 No	
F Vitz Physicia or this ce ral direc	103 2 100					sidence 6 Other		
on of adding lath. The function:	27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Year)		ry at Work? 28 Yes 2 No	d. Describe how	injury occurred		
Division of Vital Records, P.O. Box 68760, the Hospital ar Attending Physician: The law requires that the death certificate be executed the Paneral Director: After this certificate has been signed by the attending physician and applietly filled in by the funeral director, page 2 should be detached for use as the burial - trans lical Certification: To Be Completed by Physician/Medical E.	2 Accident Investigation 3 Suicide 6 Could not be determined Homicide 4 Homicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)							
Divisior To the Hospital nr Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificatic	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  One)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
¥ 5 ± 8	29b. Signature and title of certifier		29c. Licens			d. Date signed (Mo	nth, Day, Year)	
d	30 Name and address of pares who	completed cause of death /Hom 22	O.C.	M. <b>∟</b> .	^^	ugust 8, 2012		
<b>\( \rangle \)</b>	30. Name and address of person who Ana Rubio M.D., Ph. D.	Assistant Medical Examin		Street, Baltimoi	re, MD 2122	3		
State	31. Date filed (Month, Day Year)	32. Registrar's Signature	ale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year Charlotte 6:20 A Jarzynski August Medical **€**xaminer 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Queen Anne County 3023 Bennett Point Road Queenstown Social Security Number 7. Age (In vrs. last birthday) f Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 215-16-1516 Hours (Month, Day, Year) **Director** 1 □ M 2 🕱 F 89 March 7,1923 Maryland Usual Residence of Decede shov 10b. County or 28a-f sho notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🖁 No MD Queen Anne's Queenstown 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ıral", or items 23a oı Examiner must be ı 21658 Funeral 3023 Bennett Point Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force
1 Yes 2 Black, White, etc. þ 1 Never Married 2 Married 2 **X** No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XXNo Specify: White "natural", Specify: 3 X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Heating & Air Condition Bookkeeper of and 2 should be filed with of Health and Mental Hygier If item 27 is marked other t r other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Truelock Harman န Charles F. Mewshaw, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maggie Jaye (Daughter) PO Box 788 Millersville, Maryland 21108 t: If item 2' 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ģ permit. Page 1 Department of Important: If it any injury or o 1XXBurial 2 Cremation 3 Removal from State Meadowridge Mem Park 8/9/2012 nation 5 Other (Specify) Elkridge, Maryland <sup>22</sup> Name and Address of Facility Gary L. Kaufman Funeral Home at MMP 7250 Washington Blvd. Elkridge, MD ature of Funeral Service Licenses 21075 Elkridge, MD er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest of heart failure. List only one cause on each line. Approximate Interval Between Immediat ause (Final Onset and Dear Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at the detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page 2 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 NR Residence 6 Other (Specify) 1 Yes မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of D-ath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Merical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated efflying Nurea Prantitioner. To the best of my knowledge, diet the time ideterand place, and due to the 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) DOLOUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Poornima Sharma, MD, 203 Hospital Dr., Suite 312, Glen Burnie, MD 21061 AUG 1 3 2012 31. Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 9 per FH, 6930, 8/14/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month ARCHIBALD JUNES 1116 AM WILLIAM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death county General Colum bia MOWARD Howard Huspilal If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days Min. Months Hours 05/20/1920 New Jersey Director 197-05-6663 92 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10h. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Howard Columbia 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 6020 Jamina Downs 21045 USA "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No WWII Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Government Letter Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Henry Jones Bertha Still 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 Irene Closson (Daughter) 6020 Jamina Downs, Columbia MD 21045 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 a 1 X Burial 2 Cremation 3 Removal from State St. John's Cemetery 8/13/2012 4 Donation 5 Other (Specify) Ellicott City, MD permit. 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility Tri-State Funeral Service alls 814 Upshur STreet, NW, Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTE INFARCTION MYUCARDIAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (u. as a consequence of). or Attending Physician: The law requires that the death certificate be executed the burial-transit HYPERTENSION and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 🔲 Ectopic pregnancy for 1 in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 27. Manner of Death 28a, Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 1 Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioners To the best of my knowledge, death occurred at the time, date and place, and due to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D74058 Sh 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BHAKTI HANSON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 3 2012 Backs Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State		State of	Marylan				and M			201	2	25617
			Registrar  1. Decedent's Name	e (First. Middle, La	st)		Cen	ificate o	Deam		2. Date of Dea	Reg. No.	. Z U	-	2554 / 3. Time of Death
, c F	Physicia	n/			Kilgore						Month	Day	y Yea		2350 M
AND THE REAL PROPERTY.	Medic Examin		4a. Facility Name (if			er)		4b. City, Town	, or Location	of Death		4c.	County of De	eath	
				General				Berl		04 Hz T		_	Worces		
	Funeral		5. Social Security No		ex 7. □ M 2 🛣 F	. Age (In yrs. Ia	-	If Under 1 Ye Months Day		Min.	8. Date of Birt (Month, Day		9. (	Birthpla Co <i>untry</i>	ce (State or Foreign ')
-	Director		216-40-4 Usual Residence	1170	L M 2 KJF		68 Yrs.				10/06	/194	3 I	Dela	ware
land	shov d at	to	10a. State	10b. County		10c. City	, Town or Loc	ation						100	d. Inside City Limits
Mary	28a-1 otifie	Director	MD	Worces	ter	В	<u>erlin</u>								1 🗌 Yes 2 🔀 No
th the	3a or t be n		10e. Street and Nun					10f. Zip Cod					izen of What	Country	y?
ath wi	ms 2	Funeral	11303 As	ssateague	ROAD 12. Was Decede	ent Ever in U.S	3. 13. W	2181 as Decedent of	of Hispanic O	rigin? (Spec	ify Yes or No-		14. Race - A	mericar	ı Indian.
<b>15-0036</b> 72 hours after death with the Maryland	and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, <u>the M</u> edical Examiner must be notified at	by F		ried 2 Married	Armed Force	es?	lf lf	Yes, specify C	uban, Mexica	an, Puerto F	Rican, etc.)		Black, W		
<b>)03</b>	ural", Il Exa	ted	3 🔀 Widowed	4 Divorced	If Yes, Give Year or Date	es.		Yes 2 🕱		y: 			Specify:	Whi	te
<b>15-(</b>	"nat edica	Completed	(Spe	15. Decedent's E ecify only highest gi			(Give k	ent's Usual Occ ind of work don NOT use retire	ne during mo	st of workin	g	16b. K	ind of Busine	ss/Indu	stry
<b>21215-0036</b> within 72 hours after	r thar	Con	Elementary/Seco	ondary (0-12)	College (1-4	or 5+)		o Desig				V	Web Des	sign	)
Z N	othe othe		17. Father's Name (	First, Middle, Last)						her's Name	(First, Middle,	Maiden	Surname)		
Maryland 2 should be filed	Venta arked atic e	욘	Howard	Marvel					El	izabet	ch Ho	llar	nd		
lan shoul	and is m		19a. Informant's Na	ame/Relationship (	Type, Print)			g Address (Stre							de)
9, S	Health		Samuel I	Kilgore /	Son	201- 5		1 Assat			Berli		1D 218. ocation - City		n Stato
2349 altimore	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, <u>the M</u> edical. once.		1 🗌 Burial 2	Cremation 3	Removal from S	tate c	emetery, crem	atory or other	place)				over,		
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5			23a. Part 1. Enter t	the disease, or con	nplications that ca	used the deat	h. Do not ente	r the mode of o	dying, such a	s cardiac o	respiratory ar	rest,		í	Approximate nterval Between
	/moioley		Immediate Cause disease or condition	(Final			Asc	VO						(	Onset and Death
	Medical caminer		resulting in death)		Due to (or	r as a consequ	uence of):								
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ted %	ınsit	Examiner	cause. Enter Unde Cause (Disease or	erlying injury			,								
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5/4/5 Box 6	attend for us	Physician/Me	23b. Was decedent in the past 12	months?	1 🗀 Live B	irth 2 Teta ant at time of o	al death 3 🗌	Ectopic pregr				ĺ	23d. Date of Month		y Day Year
. B.	y the a	hysi	1 Yes 2 9 Unknown		9 🗌 Unkno										
208:10/6 ords, P.O. E	ned b e deta	y P	Part II. Other signi	ficant conditions	contributing to dea	ath but not res	sulting in the u	nderlying cause	e given in Pa	rt I.					cause of death?
Solg.	en sig ould b	ted									1 🗆	Yes 2	□ No 3 □	Proba	ably 4 <del>3 Un</del> known
Records,	as be	Completed by									24a, Was auto		24b. Were prior deatl	to com	sy findings available pletion of cause of
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f Vital Physician:	certifi	To Be	25. Was case referrexaminar?		Hospital:		ER/Outpatien		6. Place of De				C C C++ (C		
5 5 V	eral di	e: To	27. Manner of Deat		28a. Date o	f injury	28b. Time of	28c. l	njury at		me 5 🗌 Resi 28d. Describe l			pecity)	
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e, Erma E Division of Vital	er de recto by th	Certificate:	3  Suicide 4  Homicide	6 U Could not determined	,   28e. Place c	of Injury - At ho g, etc. <i>(Specif</i> )		et, factory, offi	ice		28f. Location ( City or Tox	Street an wn, State	nd Number or e)	Rural F	Route Number,
وانعان وانعان	ours af		00- 0-46	1 Certifying Ph	veision. To the be	et of my know	ledge death o	occurred at the	time date a	nd place ar	nd due to the c	ause(s) a	and manner a	s stated	
ifgore Div	within 24 hours af er death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Chook	1 ☐ Certifying Ph 2 ☐ Medical Exar 3 ☐ Certifying Nu	niner: On the hasis	of examination	n and/or invest	igation in my o	pinion death	occurred at	the time, date :	and place	e, and due to t	the caus	se(s) and manner stated.
ام الله الله الله الله الله الله الله ال	withir To the comp	2		title of certifier				29c. Lic	ense number	r		29d. Da	te signed (Me	onth, Da	
				Sw	)				5049			8/	8/12	-	
			Chris	ress of person who	completed cause		n 23a) (Type, F . <b>Cerro</b> l		Salvi	shy	wo	218	301		
	Sta Registr		31. Date filed (Mon	3 2012	Serva 32. Re	gistrar's Signa	ture back	,							

1. Decedent's Name (First, Middle, Last) 2. Date of Death Awo Keckler **Physician** Daisi 2012 /Medical 4c. County of Deal 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death **Examiner** wel trno are Chosapeak ld If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours 1 ☐ M 2 🕱 F Yrs. 563-34-5058 89 08/03/1923 Director Usual Residence of Deceden death with the Maryland 10c. City, Town or Location 10a. State 10b. County rel', or iteme 23a or 28a-f ehow Exeminer must be notified at Anne Arundel Annapolis Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 130 Hearne Road, Apt. 1303 21403 Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Item eny injury or other traumatic event, the Medical Examinations. 1 ☐ Yes 2 🔀 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Simms William Shepard Naomi Ida 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Ford Circle, Annapolis, MD 21401 Joseph F. Keckler, Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/09/2012 | Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Covernovascular Accident **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical as ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown ģ signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably certificate has been signector, page 2 should i Completed 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No ) ise it cu lum the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To After this funeral 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 Pending 1 TYes 2 No investigation 2 Accident within 24 hours efter death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

25648

3. Time of Death

Birthplace (State or Foreign Country Arkansas

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

Yweeles ago

Year

Unknown

1K Yes 2 No

10:00 PM

State Registrar

Medical

(Check only one)

29b. Sigpeture and title of certifier

1 - For State Registrar

who completed cause of death (Item 23a) (Type, Print) (S, 6 fen Bierme, MD 2106) 32. Registrar's Zignalure

💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

FC2153891

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death Day 2012 Physician/ Month Soon Kwon August 4 11:50A. <sup>™</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 1030 E. 33rd Street - Apt 415 Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 216-02-3408 Director 1 M 2 X 03-01-1918 Korea Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 1030 E. 33rd Street - Apt 415 21218 United States items 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces "natural", or ş 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3XXWidowed 4 □ Divorced Asian Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 6 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. (Unavailable) (Unavailable) Park 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Miae Park - granddaughter 2 Reservation, Monroe Township, NJ 08831 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-09-2012 Atlantic Crematory Glen Burnie, MD Fineral Ser ice Livens/ e 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signatu MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician HYPERTENTION disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, isaging to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a so isequence of. law requires that the death certificate be executed and -tran resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Records, P.O. Box 68760 as attending properties IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death the 1 ☐ Yes 2 = 9 ☐ Unknown 9 Hinknown signed by to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page performe this certificate 2 N 1 🗌 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 4 Nursing Home 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Director: After Natural (Month, Day, Year) 5 Pending death. 1 Yes 2 No Accident the Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a Medical 29a. Certifier Ϊ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D25654 2012

Registrar

DHMH 17 Rev 06-201:

FONG

31. Date filed (Month, Day, Year)

CRAIN

2106

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1412

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 25650 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 11:20a M Demetrios George Kalapothakos August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 14644 Stonewall Drive Silver Spring Montgomery 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 579-74-8749 1 🕅 M 2 🗆 F Director 66 April 30.1946 Greece Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20905 14644 Stonewall Drive should be filed within 72 hours after death vand Mental Hygiene. is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂢 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc <u>\$</u> 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 nan "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify White 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the General Contractor Business Owner 12 other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Georgia Solomakos George Leonidas Kalapothakos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14644 Stonewall Dr., Silver Spring, Maryland 20905 1 and 2 s of Health item 27 Andriana Kalapothakos/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 7 1 🛱 Burial 2 🗆 Cremation 3 🗆 Removal from State Silver Spring, MD 08/13/2012 Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 years Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 2 No the a g 🗌 Unknown signed by till Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus Type 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hypertension After this certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pi 124 hours after death. e Funeral Director: After tl 28c. Injury at 28d. Describe how injury occurred work?
1 \( \sum \) Yes 2 \( \sum \) No 1 X Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

To the I within 2

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one 29b. Signature and

> 12520 Prosperity Dr., Silver Spring, Maryland 20904 M.D., Kenneth Khandagle. 32. Registrar's Sign

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D61007

29d. Date signed (Month, Day, Year)

August 09, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 8, 2012 Year Physician/ 11:45 PM Marie Keavenv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stell Maris If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** April Pay, Year) New York 1919 129-10-5987 93 1 □ M 2 🗓 F **Director** show 10a. State 10c. City, Town or Location 10d, Inside City Limits must be notified at Director 28a-f 1 Yes 2 X No Baltimore Perry Hall Marvland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21236 U.S.A. 8406 Tachbrook Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 11, Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ked other than 's event, the " Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) id Mental F marked of ၉ Coffey Mahoney Thomas Mary other traumatic and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 8406 Tachbrook Road Baltimore, Maryland 21236 Chuck Olkowski / Son-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of P P 1 Burial 2X Cremation 3 Removal from State Important: If any injury or Hilltop Service Corp. 8/10/12 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature dervice Licens 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 hplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be INNA KEAVENY AUGUST 8, 2012 Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Other (specify) 1 Yes 2 been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy funeral director, page 2 perform 1 Ves 2 No 1 Yes 2 No certificate 25. Was case referred to medica 26. Place of Death (Check only one) examiner? ANNA KEAVENY ပ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes 2 No 1 X Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director; / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie unecra

Registrar
DHMH 17 Rev 06-2011

State

2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Registrar's Signature

JUNECIA WHITE,

3

31. Date filed (Month, Day, Year)

AUG 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Physician/ 2012 Н. Klosteridis 1:51 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 17 1930 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 216-30-5521 1 □ M 2**X**□ F 81 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits ms 23a or 28a-f sho must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Directo Baltimore Maryland Timonium 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1502 Pot Spring Road 21093 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give ö 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than 'event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Antiques Be Department of Health and Mental Hy Important: If Item 27 is marked oft any Injury or other treumatic event Once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zenon Pistolas Evanthia Kakouli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John V. Klosteridis / Husband Pot Spring Road, Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 8/11/2012 Baltimore, Maryland Greek Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Samuel Conse 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide 28a. Date of injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No be to the state of Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifie within 2 ylly one) nd title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) will a Shakeeu, 6701 N. Charles St. #4105, Baltimore, MD

Registrar

DHMH 17 Rev 06-2011

State

(Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Losovsky May 2012 Dorothy 11:30 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co North Point FutureCare North Point Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Days Hours 220-30-3621 **Director** 1. M 2 X F 79 Yrs Oct. 18,1932 Maryland 28a-f show 10a. State 10c. City. Town or Location with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at Director Dundalk 1 Yes 2 X No MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 1901 Tolson Avenue be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced "natural" Completed White Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Years Be traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည Leona J. Spina permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Millard Filmore Humphreys 19a. Informant's Name/Relationship (Type, Print) Daughter, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1901 Tolson Avenue Dundalk, Maryland Mrs. Francine L. Miller 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2X Cremation 3 Removal from State Hilltop Service Corp. 8/10/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Justin A. Jones Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Approximate on each line Interval Between Onset and Death Immediate Cause (Final ebra Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last nding physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No ဥ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending injury Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director. A Investigation ccident 6 🗆 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 📮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 [ 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29b. Signature and title 8 30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) 4 State

DHMH 17 Rev 06-2011

Ana Rubio M.D., Ph. D. 31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

**OCME** 

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

August 8, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2012 1:30 Рм William Anthony Lejewski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) Director 217-20-5036 83 1 KM 2 🗆 F Yrs Tuly 11, Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 24 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21224 415 S. Anglesea Street 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No 1948—
If Yes, Give 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify white 3 Divorced 1952 Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 police officer law enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josephine Eva Odohuski Frank John Lejewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Huxley Circle; Abingdon, MD 21009 Kathleen Morawski - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Eu eral Servin, License Ronald S. 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final -- nysician/ ADVANCED disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediat cause. Enter Underlying Due to for as a nonsequence of attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 4 Pregnant at time of death signed by the at 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ INTERSTITIAL LUNG DISPASE 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been signated 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an TOS EXPO cate has to page 2 s autopsy performed? CORONARY this certificate 2 - No 1 Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 1 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) Hospital 1 Yes 2 1 No ၉ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 72 ad address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed /A State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Markwood Madigan 8:00P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Swanton Garrett III Lower White Oak Rd Lot 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 214-82-2473 Hours (Month, Day, Year) Director 1 0 M 2 □ F 48 Md. 6-11-64 filed within 72 nous are real Hygiene.
ed other then "neturel" or items 23e or 28e-f show ed other then "neturel" or items 23e or 28e-f show event, the Maxilda Extrainer rate the motified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Mo Garrett Swanton 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral III Lower white Oak Rd 21561 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Š 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ond Mentel 3 ၉ treumetic William Henry Madigan Sarah Itnyre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 s of Health ( Patricia Madigan / Spouse 111 Lower White Oak Road, Lot 6, Swanton, MD 21561 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pege 1
Depertment of 1
Importent: If it
ony Injury or of 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 08/10/2012 | Hanover, Maryland 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician Cancer UV Medical resulting in death) Due to (or as a consequen bof) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burlel-transi To the Hospital or Attending Physiclen: The law requires that the death certificete be executed that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the ettending physicien should be detached for use es the burle Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 5 autopsy performed? within 24 hours after death.

To the Funerel Director: After this certificate is completely filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 115333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

Thomas Johnson,

1. Date filed (Month, Day, Year)

AUG 1 3 2012

311 N.

32. Registrar's Signature

4th Street, Oakland, MD 21550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:50 AM August 11, Melissa Dunham McCarty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson Date of Dis... (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. 1918 New York 94 Director 213-20-7366 Usual Residence of Decedent 10a, State 10b. County 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f sho 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21212 United States 213 Woodbrook Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: Specify: 3 XWidowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event. If we may Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nelson Whitney Dunham Melissa Brownell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa McCarty Warlow /Daughter 213 Woodbrook Lane Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 D Removal from State cemetery, crematory or other place) Aug 13 2012 Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 401585 Cremation and Funeral Alternatives non 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ CAN resulting in death) Medical Due to (or as nsequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit Hospital or Attending Physician: The lew requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Records, P.O. Box 68760 🖄 physician Physician/Medical the ed by the attending I IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobasco use contribute to the cause of death? Completed by FIBRILLATION cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed 1 ☐ Yes 2 🗗 No 24 hours after death.

Pruneral Director: After this certificate I letely filled in by the funeral director, pag Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) + OSPICE 2 🛂 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 8c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Accident Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie of death (Item 23a) (Type, Print) d 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20/a 31 Mary Elizabeth Miller la Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death tagerstown Washington Kavenwood Lutheran VIIVaok If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday, 8. Date of Birth (Month Day, Aug 21, 9. Birthplace (State or Foreign Months 1 □ M 2 🔀 F Days Hours Min. Maryland 95 217-10-5627 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ▼No Hagerstown MD Washington 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21420 USA 7 E. Washington St #306 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █️No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☐ No Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bon-Ton sales clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Mae Stuby Robert Keller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5624 Stone Bridge Rd; Green Castle, PA 17225 19a. Informant's Name/Relationship (Type. Print) Anna Devos 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licenses, Romald S. Wade, 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 m Approximate Interval Between Onset and Death 23a. Part \( \) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 🗖 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Nio 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? Yes 2/5/No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Mudical Examinar I, set the nutified at agnes. 90nes.

Itimore,

Division of Vital Records, P.O. Box 68760,

/Medical

Director

Funeral

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Completed

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attending physician and for use as the burial-transit

Examiner been signed by the should be detached funeral director, page 2 should

Physician/Medical <u>Ş</u> Completed Be Certification: To

3 Suicide 4 🗀 Homicide

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

Signature and title of certifier	
Dalid ~	^

580 C. MORTHERM

uhmood 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

301.3233

0

State

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year) AUG 1 3 2012

AVELUE HAGERS TOWN MD 21742

Registrar

within 24 hours a

To the Funeral L

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene

		ľ	1 - State Registrar	,	Cer	tificate of L	Death		,	Reg. N	o.			
	Physicia	m/	1. Decedent's Name (First, Middle, Las	t)					2. Date of Dea	ath			3. Time of Death	
	Medic		Sylvia Mae Mc					į,	Aug.	9	ay 2012	. (	5:21a	M
)	Examin	er	4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of	of Death		4	c. County of Dea			
			4242 Falls Rd.			Manc					Carr	01.	<u> </u>	
	Funeral Director		5. Social Security Number 6. Security Number 1.	7. Age (In yrs. le		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day		9. B C	irthplac o <i>untry)</i>	e (State or Forei	gn
			Usual Residence of Decedent	<sup>1</sup> 86	Yrs.				Aug. :	11,	1925	Maı	ryland	
	shov d at	p	10a. State 10b. County	10c. City	, Town or Lo	cation						10d.	Inside City Limit	is
	Mary 28a-f otifie	irec	Maryland Carro	ll Man	nches	ter							1 ☐ Yes 2 🔀 1	No
	with the 23a or 3 st be no	Funeral Director	10e. Street and Number 4242 Falls Rd.	-		10f. Zip Code 2110	2				itizen of What C	ountry	?	
	tems er mu	Fun	11. Marital Status	12. Was Decedent Ever in U.S		Vas Decedent of H	spanic Ori	gin? (Speci	fy Yes or No-		14. Race - Am	erican	Indian,	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 ☐ Married 3 😾 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates.		f Yes, specify Cuba I ☐ Yes 2 🔀 No			can, etc.)		Black, Whi Specify: W	ite, etc. Ihi t		
ر ک	2 hou "natu edica	plet	15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occupa	ation	t of working	,	16b.	Kind of Business	s/Indus	try	
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au	be filk	To E						,	First, Middle,		,			
$\overline{\Sigma}$	ould ould mark		Harry W. Whalen 19a. Informant's Name/Relationship (Ty	rne Print)	10h Mailie	ng Address (Street a			rie For	_		r- 0- d	-1	
Š	I2 sh Ilth ar 27 is r trau	Ì	Sarah J. Wagner (			Manheim						ір Соа	e)	
ē,	1 and if Hea item othe		20a. Method of Disposition	20h B	lana of Diana	nition (Name of	- 1	Da			ocation - City o	r Town	, State	_
E E	Page nent o nt: If ry or		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State Jef	metery, cren fersor	natory or other place Treewil Cem.	i	8/13/	2012		ferson,			
Baltimore,	permit. Page 1.8 Department of H Important: If ite any injury or ot		21. Signature of Fune Ther collicens	ee/	22	. Name and Addres	s of Facilit							Α.
ñ	and Land		My Jun Olymic	uh-		296 Chai								21
)	Physician/ Medical		23a. Part 1. Enter the disease, or come shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the death ne cause on each line.  a. Due to (or as a consequ	$\Omega$	er the mode of dying	g, such as	cardiac or r	espiratory arr	est,		Int Or	oproximate terval Between nset and Death	ļ
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VICA	ysici is cer direc	IO B	examiner? 1  Yes 2  No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3 DOA Othe	r: 4 🗆 Nu	ırsina Home	s 5 Reside	ence	6 ☐ Other (Spe	cifv)		_
5	ng Pt ter th ineral		27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at		d. Describe ho			//		
VISION	eath. or; Af the fu	lica	2 Accident Investigation 3 Suicide 6 Could not be		,,		Yes 2 🗆	No						
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 semples.	al Certificate:	4  Homicide determined	building, etc. (Specify)				- 12	City or Town	n, State			ute Number,	
	the Hosp nin 24 hou the Funei npletely fi	Medical	(Check 2 L Medical Examin	ician: To the best of my knowle ner: On the basis of examination e Practitioner: To the best of m	and/or invest	gation, in my opinio	n. death oc	curred at the	e time, date ar	nd place	e, and due to the	cause(s	s) and manner sta	ited.
	Voir		29b. Signature and title of certifier			29c. License	number	711	2	29d. Da	ate signed (Mont	h, Day,	Year)	
			INON IN	77		000	1510	140	1	Jug	454 00	7, 2	1012	
	/		30. Name and address of person who c	ompleted cause of death (Item	23a) (Type, P	rint)	. 1	to-D	1 IAA		host.	_ n	1121	7
	Stat	e	31. Date filed (Month, Day, Year)	32. registrar's Signati	ilea « »	7/5/11/10	K h 25	14/	-CIC VOI	UW	VIE 3 17.	/ (V	- VIII	4
			AHI- 1 3 70°	17 / /2		0. 1. 1								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Leona J. Nicolaidis 2012 440 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN Baltimore Square Hospital Rusedale If Under 1 Year | If Under 24 Hrs. ] 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 7. Age (In yrs. last birthday) Months 1 □ M 2 🗓 F Days Maryland 212-60-5422 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Baltimore Co. Sparrows Point 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2509 Steel Avenue 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 🛛 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify Ş Specify: White 3 Widowed 4 Divorced "natura!" other than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)  $\overset{\text{College,} (1\text{-4or }5\text{+})}{N/A}$ Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert John Smith Doris Bowman 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Steel Avenue Sparrows Point, MD 21219 Emmanuel Nicolaidis 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-11-2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Systemic inflammatory response disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading of interesting cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Peripheral vascy lar Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No Atherosclerotic Cardiovascular autopsy performed chronic malnourichment 1 ☐ Yes 2 ☐ No funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiel Medical

Division of Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the To the Hospital

Maryland 21215-0036

Itimore,

State Registrar

31. Date filed (Mt Year)

Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b.



29c. License number

D0060560

29d. Date signed (Month, Day, Year) BUGUST 9,2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For	State of Maryland	-			lental Hyg	iene 21	112	25661
			Registrar  1. Decedent's Name (First, Middle, Las	n#1	Certif	icate of Deat	<u>n</u>	2. Date of Deat	leg. No.		
	Physicia	n/	1. Decedent's Name (First, Wilddle, Las		100 k			Month	Day	Year	3. Time of Death 2'34'A M
~	Medic		4a. Facility Name (if not institution, give			o. City, Town, or Locati	ion of Death	AUgust	4c. County	of Death	2374
)	Examin	er	The Sonns Hope			Baltimor		rc1			
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. la			nder 24 Hrs.	8. Date of Birth (Month, Day)	Year)	9. Birthp Count	lace (State or Foreign
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	nd how at	٦	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location	on		<del>зере 23</del>	1 2 2 0		0d. Inside City Limits
	larylar 3a-f s iffied	Director	PA Sherr	stown							1 🗌 Yes 2 🗓 No
	or 28	ă	10e. Street and Number		T	0f. Zip Code			10g. Citizen of	What Coun	try?
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	death item ner n		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No	. 13. Was	Decedent of Hispanic s, specify Cuban, Mex	: Origin? (Spec kican, Puerto F	cify Yes or No- Rican, etc.)		e - America ck, White, e	
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 L Yes 2 ANo If Yes, Give Year or Dates.	1 🗆	Yes 2 No Spe	cify:		Specify	whit	e
9	hours natura lical E	Completed	15. Decedent's E	ducation	16a. Decedent	's Usual Occupation			16b. Kind of B	usiness/Ind	dustry
215	in 72 e. nan "r	duc	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO N	of work done during r OT use retired)	most of workir	ng			
7	ygien ygien her th	Be Co	12	0	rece	ptionist				omini	num
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	To B	17. Father's Name (First, Middle, Last)  Abner Forney					e (First, Middle, I eth Hou		e)	
Ž	ould bould by mark		19a. Informant's Name/Relationship (	Type. Print)	19b Mailing A	ddress (Street and Nu	ımber or Rural	l Route Number	City or Town.	State. Zio C	Code)
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Baltimore,	1 and of Hea item other	i	20a. Method of Disposition		lace of Disposition	on (Name of ory or other place)	0	Date	20c. Location	- City or To	wn, State
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9	death certificate be executed ne attending physician and ed for use as the burial-transi	Physician/Medical		d			· ·				
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ita	Physician: this certificeral director,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		Other:	Death (Check			(0)	
of V	> 0) 0	e: 10	27. Manner of Death	1 Inpatient 2 2 28a. Date of injury	28b. Time of	28c. Injury at		me 5 Resid			7
on C	Attending For death.  ector: After to by the funer.	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work? M 1 ☐ Yes	2 🗆 No				
Division	l or Atteno after deatl Director:	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		me, farm, street	factory, office		28f. Location (S City or Tow		er or Rurai	Route Number,
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	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check 2 Medical Exam	ysician: To the best of my knowl niner: On the basis of examination rse Practitioner: To the best of n	and/or investiga	tion, in my opinion, dea	ath occurred at	the time, date a	nd place, and du	e to the ca	use(s) and manner stated.
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			30. Name and address of person who		23a) (Type, Prin	t)		- 1-	41		3,7
			Bahar Miss	MD	1800 O	e leans Str	eet Bal	timore, t	PA 318	387.	
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12-05695 Justin A. Ogle

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Ce	rtificate o	f Death			Reg	g. No.		
Physicia	an/	1. Decedent's Name (First, Middle							. Date of Death Month	Day Yea		3. Time of Death
Medical Exami	ner	Justin A.							July 31, 20	12	- ( D - a )	0726 hrs
		4a. Facility Name (if not institution Pataspsco Road and E	-	iumber)		4b. City, Town, o Woolreys	or Location o	of Death		4c. County of	or Death	
Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ear If Unde	er 24Hrs.	8. Date of Birth	(MM/DD/YYYY	9. Birth	place (State or
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	×	MD Balt	imore			Rose	dale					1 Yes 2 XXNo
Aaryla 28a-f	ec.	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wh	nat Count	ry?
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36 thin 7 than edical	힐	12		,		Stud	ent			Educ	cati	on
5-00 ed wi Hygier other	S	17. Father's Name (First, Middle,	Last)				18.Mother	's Name (F	irst, Middle, M	aiden Surname)	)	
21. be fill sit all brinked rent, j	å	Steven Harold	0					-	Jane Be			
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f shoumatic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relationsh				g Address (Stre						
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Sior Attend r death ector: by the	Cati	2 Accident Inves	tigation Id	7-31-12 ce of Injury - At h	fd 07:	13 am			8f. Location (St	reet and Number	er or Rura	al Route Number, City
Division pital or Attendiours after death. teral Director: Affilled in by the fi	Certification:	3 Suicide 6 X Could determ	not be	Local S		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<b>3</b> ,			ete) Pataps	sco ]	
Divi		20a Cartifiar	ysician: To the be			rred at the time,	date and pla			•		
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical		<b>niner</b> :On the basis and manner		and/or investiga	tion, in my opinio	on, death oc	curred at t	he time, date a	nd place, and d	ue to the	cause(s)
To witi	Me	29b. Signature and title of certifier		1/ 500			nse number			29d. Date signe	ed (Mont	h, Day, Year)
		Much	Trassell	MA		0.0	.M.E.			August 1, 2	2012	
		30. Name and address of person				( D . W	Ob. : =	-14.	MD 0125			
		Melissa Brassell, MD	Assistant M	edical Exami legistrar's Signat			Street, B	altimore	, MD 21223	3		
Si Regis	ate trar	31. Date filed (Month, Day, Year)	2012	Augustian s Signat	8. Aa	New Y						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND PITEM#31 per DVR, g930, 8/13/2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month OS 4a. Facility Name (if not institution, give street and number Ch Ovelgone 2012 12:15 pM 11 Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bayview Medical Campus Baltimore United States Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
08/22/1929 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In vrs. last birthdav) Funeral 1 M 2 F Days Hours Min 83 216-24-2785 Director Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Dunda1k Maryland Baltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8157 Kavanagh Road 21222 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 3 ₩idowed 4 □ Divorced Year or Dates Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien? General Motors Corp. Utility Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Grace Bernett Clemsen John Joseph Ovelgone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Relimore MD 21222 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sharon C. Ovelgone (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemeter, crematory or other place)
Oak Layin Cemetery 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 8/15/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 18 22. Name and Address of Facility 21. Signature of Funeral Service iceps Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ About the as Due to (or as a consequence of): disease or condition resulting in death) unknown Medical Examiner oronary Avtery unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the attending phase to the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stenosis 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Mellitus Diorbetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 \( \subseteq \text{No} \) 2 🗆 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier Fatima Sheikh D73968 8/11/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheikh Bayview Medical Center, Baltimore, MD 21224 Fatima Johns Hopkins 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 3 2012 Registrar 08/12/

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #9, per fh, 2930 8-14-12 sm
State of Maryland / Department of Health and Mental Hygiene 2 2 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 10:50 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner M(0)8. Date of Birth (Month, Day, 9. Birthplace (State or Fpreign Country) Maryland Age (In yrs. **Funeral** Min. Hours Director Usual Residence of D redent 28a-f show 10d. Inside City Limits 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No 10g, Citizen of What Country? 10e Street and Number Funeral U.S.A. 42 E. Baltimore Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Insurance 12 Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Magnolia Tanner Manual Charles Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 N. Main Street, Union Bridge, MD 21791 Sheila Shogren / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 08/13/2012 4 X Donation 5 ☐ Other (Specify) Hanover, Maryland Anatomy Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the clisease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner School tally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown g 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe 1 ☐ Yes 2 ☐ No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes ER/Outpatient 3 DOA 1 Inpatient 2 Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State Registrar (Check

only one 29b. Signature

with

Baltimore, Maryland 21215-0036

that the death certificate be

# Upivision of Vital Records, P.O. Box 68760

32. Registrar's Signature

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

s of person who completed cause of death (Item 23a) (Type, Print)
PN 130 LARCY, 1967 JOHUE, FRED ENCK, NO 21702

29c. License number

DO062223

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ UC Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death ore Samaritan HOSPITZ n vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 63 **Director** 1 M 2 XF 12/08/1948 MARVIAND Usual Residence of Decedent 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore MD 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Care 536 U.S.A. 21217 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Never Married 2 Married þ Yes 2 No 1 Yes 2 No Specify If Yes, Give Year or Dates. BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CARE TAKER should be filed with and Mental Hygien is marked other th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ RAYMOND RussELL permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Info ant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 GETHER BALTIMORE, MARYIAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/16/2012 BALTIMORE, MARVIAND 21. Signature of Funeral Service Licensee 22. Name and Address of Factorie DERRICK C. JONES FIH, P.A. 4611 PARK HIGHS. AVE. RALTIMORE, MARY LAND WIS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Se disease or condition Medical resulting in death) Due to (or as a conse Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 Month Pregnant at time of death Unknown 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Seare autopsy performe certificate 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after deau..

To the Funeral Director: After this committely filled in by the funeral di Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Vatural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J 0  $\supset$   $\sim$ Q Sa

Registrar

State

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 7, Day 2012 Mable 6:05 Cowan Rogers Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bradford Oaks Center Clinton Prince George's Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours (Month, Day, Year, **Director** 240-80-3311 1 □ M 2X F 98 June 15, 1914 Usual Residence of Decedent North Carolina or. 28a-f show 10c. City, Town or Location ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🖾 Yes 2 🗌 No Prince George Temple Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20748 6305 Larwin Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black Completed 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Personal Sewing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Edward Cowan Maud Branch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Perkins - Sister 6305 Larwin Drive, Temple Hill, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o Page 1 1 Buria 2 Crestview Memorial Cemetery Cremation 3 Removal from State 4 Donation Other (Specify) 8-11-2012 Roanoke Rapids, NC 21. Signatu 22 Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 al Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line ediate Cause (Final Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 XNo Day Year signed by the at d be detached for Pregnant at time of death g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 2 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🛣 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) . Manner of Death 1 🗀 Natural 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and ti

DHMH 17 Rev 06-2011

State Registrar on who completed cause of death (Item 23a) (Type, Print)

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		Registrar	l nett	cen	fificate of	Death			eg. No.			
Physici dical Exami	C. 111	1. Decedent's Name (First, Middle, KALIF OMAR RICH						2. Date of Dea Month July 24, 2		3. Time of Death 2300 hrs		
		4a. Facility Name (if not institution, Laurel Regional Hospita	_	er)	4b. City, Town, or Location of Death Laurel				4c. County of Death Prince George's			
Funeral		Social Security Number 6	. Sex 7.	Age (In yrs. las	st birthday)	If Under 1 Yea	r If Under 24	Hrs, 8. Date of Bi	rth(MM/DD/YYYY	9. Birthplace (State or		
Director		579 19 2852	<b>X</b> M 2 F	2	1 Yrs.	Months Day	s Hours N	<sup>fin.</sup> 10/30	/1990	Foreign Country) DC		
		Usual Residence of Decedent		Tie en -								
W &B		10a. State 10b. County			Town or Location					10d. Inside City Limits  1 X Yes 2 No		
yland I-f sho	흕	MD PRINCE  10e. Street and Number	GEORGES	DI	STRICT	HEIGHTS		1,	Og. Citizen of Wh			
ith the Maryland 23a or 28a-f show a	Director	8108 PHELPS PL	ACE			207	47		UNITED	•		
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiewit Important: If item 7 is marked other than "natural", or items 23a or 28a-f she injury or other traumatie event, the Medical Examiner must be notified at once		11. Marital Status	12. Was Decede	ent Ever in U.S	i. 13. Was			Specify Yes or No		- American Indian, Black,		
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after o	by F		ced If Yes, Give Year or Dates:		1 🔲	Yes 2 X No	specify:		Specify:	BLACK		
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ould b		19a. Informant's Name/Relationship			19b. Mailing	Address (Stree				n, State, Zip Code)		
M 2 sho alth and m 27 is		Shirtia Edwards	Mother						-	MD 20747		
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rmit.		21. Signature of Funeral Service Li	censee							eral Home Inc		
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LIVISION Of VITAL RECORDS, P.O. BOX 68/60, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	9 Unknown	at time of deat	2 Feta	al death 3 [ er (Specify)	Ectopic preg		23d. Date of o	Day Year		
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After After Unera	Ë	27. Manner of Death	28a. Date of I (Month, Da	njury 2 y,Year)	28b. Time of In		y at Work?	28d. Describe	how injury occurre	ed		
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E is it is	Certification:	3 Suicide 6 Could r	lot be	_	ne, farm, street	, factory, office b	uilding, etc.	28f. Location (S or Town, S	Street and Numbe State) 13026	or Rural Route Number, City Old Stage Coa		
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To the Hospital ( within 24 hours al To the Funeral I completely filled		high		> f death (Item ?	(3a)	O.C.I	M.E.		July 25, 201	12		
To the Hospital of within 24 hours all To the Funeral I completely filled		30. Name and address of person w						21223	July 25, 201	12		

DHMH 17 Rev 1/2001 DCME 2006

Deborah Mae S		1- For State Registrar		tate of Mary	and / C		ficate of		unu	MICHICAL	- i i y (	JICI IC	Reg. No	2 (		2 2556
Physici	an/	1. Decedent's Nan										. Date of D		Year		3. Time of Death
Medical Exam	ner			Showman ion, give street and r	ou una la cur \			th City Tay	!	and an of D		Month August			Dooth	1841 hrs
		52 Carroll S		ion, give street and r	number)			b. City, Tow Westmi			eatn		- 1	lc. County o Carroll	Death	
Funeral		5. Social Security	Number	6. Sex	7. Age (In	yrs, last	birthday)	If Under 1	Year	If Under 24	Hrs.	8. Date of	Birth (MN	n/DD/YYYY)		hplace (State or
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imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a nr 28a-f sho or other traumatic event, the Medical Examiner must be totified at once.		52 Car	roll S		ecedent Eve	er in U.S.	I 13 Wa	21 s Decedent	.157		(Spec	ify Yes or I	VO-	USA 14 Race		an Indian, Black,
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If litem 27 is marked other than injury or other traumatic event, the Medical		21. Sign aure of Fu					22_N B1	ame and Ad	dress o	f Facility een F	une	ral H	ome	& Cre	mate	ory, P.A.
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	by P	Part II. Other sign	ificant condi	tions contributing	to death but	not resul	ting in the u	nderlying ca	use give	en in Part I.					_	ne cause of death?
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Divisior To the Hospital or Attend within 24 hours after death To the Runeral Director:	Medical	one) 2 🗸	Medical Exa	aminer: On the basis and manner	of examina stated.	tion and/o	or investigati	on, in my op	inion, d	leath occurre	ed at th	ne time, dat	e and pl	ace, and du	e to the	cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 2012 Physician/ 7:30 PM Gloria Dean Salisbury Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Harford Forest Hill Forest Hill Nursing & Rehab. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) UNKNOWN 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 50 **Director** 212-82-08<u>56</u> Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Harford Forest Hill MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò must be i Funeral 21050 109 Forest Valley Drive U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or iten edical Examiner I Armed Forces?
1 ☐ Yes 2 🔀 No þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Black and Mental Hygiene.
is marked other than "natural aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Unknown 16b. Kind of Business Industry Unknown 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 18. Mother's Name (First, Middle, Maiden Surname) Unknown 17. Father's Name (First, Middle, Last) Unknown Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 Rock Spring Road, Bel Air, MD 21014 Deborah Kenly / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 08/09/2012 Hanover, Maryland 21. Signatur Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any heading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 anding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Other (specify) Pregnant at time of death been signed by the a should be detached t Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has k lirector, page 2 s autopsy performed Yes 2 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) B 1 Yes 2 No Certificate: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) n 24 hours after death.

e Funeral Director: After tholeted filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 123225 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pho

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Medic Examin		4a. Facility Name (if	not institution	give street and num		,	4b. City, Town, o	or Location of		Ī	4c. County			
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should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shc raumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name ( William		ck Roche				18. Mother's Marg	's Name <i>(First, M</i> garet Ca	iddle, Maid theri	en Surname Lne Kn	eucke	er	
d 2 shoul alth and I 27 is m er trauma		19a. Informant's Na Williaπ	ame/Relationsh 1 Spear	nip (Type, Print) - SON		19b. Maili 33	21 Shanno	and Number of Driv	or Rural Boute N Ve; Bait	umber, Cit IMOTE	or Town, S	21. Zip 3	ode)	
permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.		20a. Method of Disp 1 Derial 2 4 Donation	☐ Cremation	3 Removal from			natory or other pla		Date		c. Location -		wn, State	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medica	in the past 12 in the past 12 in the past 12 in	months?		ant at time o		☐ Ectopic pregnand ☐ Other (specify) _	су			Moi		Day Year	
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nysicia nis cert I direct	To B		<b>X</b> No	Hospital: 1 ☐ I	npatient 2 [	☐ ER/Outpatier	Oth		sing Home 5	Residence	e 6 🗆 Othe	er (Specify)		
Jing Pl n. After th funeral		27. Manner of Death 1 Natural	5 🗌 Pendin	9	of injury h, <i>Day</i> , Ye <i>ar</i> )	28b. Time of injury	work			ribe how ir	njury occurre	bed		
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				who completed cause UNATHM	of death (Ite	em 23a) (Type, F	Print) AITHAN	n Wan	nc Rn	2201.	PARK	VTII	EMD-2123	i L
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2012 07 9:30 Schuler David Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Baltimore Towson Birthplace (State or Foreign Country) . Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Hours 216-78-4205 Director 1 X M 2 🗆 F Mary Tand Nov 10, 1963 48 Yrs. Usual Residence of Deced or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Timonium Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral U.S.A. 21093 306 Five Farms Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, "natural", or iten edical Examiner I Black, White, etc. 6 1 X Never Married 2 Married Completed by 1 Yes 2 No more, Maryland 21215-0036 1 Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced Year or Dates 27 is marked other than "nature traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Gifts/Assessories Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Schuler Helfrich Christian Bruce Jessica Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 21093 306 Five Farms La., Timonium, MD Jessica A. Schuler-mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State 8/10/12 Towson, MD Hilltop Serv Corp 4 Donation 5 Other (Specify) 21. Signature of Funeral Pervice Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown ision of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accider
3 Suicide within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗆 only one) 29b. Signature and title of certifie eath (Item 23a) (Type, Print), Charles & STESSO State

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8.00 A<sub>M</sub> August 2012 ea Physician/ Alfred Shoff Gerald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Hanover 7223 Bocastle Lane Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** (Month, Day, Year) Months Days Hours Min 55 377-66-6536 Director 1 **X** M 2 □ F Michigan Jan.2, 1957 show 10d. Inside City Limits 10b. County aţ 10a. State 10c. City, Town or Location Director Hanover Examiner must be notified Maryland Anne Arundel 28a-f 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21076 USA 7223 Boscastle Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 9 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natural traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Irene Ward Gerald Shoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Chong Mi Shoff - Wife 7223 Boscastle Road, Hanover, Maryland 21076 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 08/11/12 Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman F.A. @ MMP 21. Signature of Ineral Service I cense opec 7250 Washington Blvd., Elkridge, Maryland 21075 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, o shock, or heart failure List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Diabetes Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a son sequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law requires that the death Month Year Pregnant at time of death 5 Other (specify) □ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No Dystipidemia 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2X No 1 Yes Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Į. Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending s after death.

I Director: Aft 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in the position occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ August 10, 2012 nde DOOG 2545 elumbia (00 Pkrvy Ste 301, Columbia, MD 21045

Registrar

10 V

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAY - 8850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Sas Physician/ Month 1100 M John 2012 ua Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/AThe Johns Hopkins Hospital Baltimore 14 0 8. Date of Birth (Month, Day, Year) 08/12/1952 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Director MARYLAND 212-60-8441 1 XM 2 □ F 59 Usual Residence of Decedent irai", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must han material. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 XYes 2 ☐ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 302 S. WOLFE STREET 21231 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Never Married 2 【 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify.AMERICAN INDIAN 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) LABORER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ JOHN A. SAS MARJORIE McGOON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JADE DIPINO/ PARTNER 302 S. WOLFE STREET, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Decremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 8/9/12 BALTIMORE, MARYLAND 21. Signature of Fundamental Privice License Name and Address of Facility
ILLY & ZEILER INC FUNERAL HOME 21231 1901 EASTERN AVENUE, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician failure Liver disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Circhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and ched for use as the burial-transi Cause (Disease of injury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N this certificate 2 🗆 No 1 Yes 25. Was case referred to medical the funeral director, To Be 26. Place of Death (Check only one) Other: 2 No 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2012 es-000 August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 0

State

Registrar

31. Date filed (Month. Day

Registrar's Signatu

3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25674 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1728 M Wayne Gene Soulea August 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 141-34-3822 Director 1 X M 2 □ F 67 09/09/1944 New Jerseu Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** ms 23a or 28a-f s must be notified Maryland 1 Yes 2X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13817 Ivywood Lane 20904 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Armed Forces Black, White, etc. o X Yes 2 No 1961 – Yes, Give Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify: White 3 Divorced Year or Dates. 1970 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Technical Writer Communications and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Clarence Joseph Soulea Olive Celestia Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Carol Gail Soulea - Spouse 13817 Ivywood Lane, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory: 08/13/2012 | Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Artery Disease 6 years Medical Due to (or as a consequence of Examiner Congestive Heart Failure 6 years Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Diabetes 10 years that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Chronic Kidney Disease 6 years Box 68760 detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has performed 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Inpatient 2 K ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 🗶 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide
Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year)

Registrar

P.O.

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Melissa Friedland,

31. Date filed (Month, Day, Year)

AUG 1 3 2012

D32923

M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910

August 07, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

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5810 Connecticut Chevy Chase	y Year 4445 have
4a. Facility Name (if not institution, give street and number)  5810 Connecticut  4b. City, Town, or Location of Death Chevy Chase  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year If Under 24Hrs.  Months Days Hours Min 1 0 (111 / 11	4c. County of Death Montgomery
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birthday  Months Days Hours Min 10 (131 (131))	
Months Days Hours Min 10/11/1	MUDD BOOOM O Pirthologo (State or
	Foreign
Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location	10d. Inside City Limits
	1 X Yes 2 No
Toe. Street and Number 106. Street and Number 107. Zip Code 20015	Citizen of What Country?
DC Washington  10e. Street and Number  3050 Military Road, NW, #309  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)	U.S.A.  14. Race - American Indian, Black,
11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify.  or Dates:  15 December 4 Education (Specify on Dates)  16 December 4 Divorced If Yes, Give Year 1 Divorced If Y	Specify: Caucasian
15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired)  16b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maide)	DC Public Schools
The continue of the plant of	· · · · · · · · · · · · · · · · · · ·
Oren Ralston  Rey  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number,	
Katheryn Yasuoka - Daughter 18116 Rolling Meadow Way, Olne  20a, Method of Disposition   20b. Place of Disposition (Name of cemetery, Date 20c.	y, Maryland 20832
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)	
4 Donation 5 Other Specity:  1 Signature of Funeral Service Lice see  22 Name and Address of Facility Hines-Rinald	rentwood, marykand Li Funetal Home Inc
The state of the s	lver Spring,MD 20904
Physician  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s failure. List only one cause on each line.	shock, or heart Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
cause. Enter Underlying Cause (Disease or injury that initiated	
events resulting in death) Last Due to (or as a consequence or).	
Denote the state of the state o	
The first of the f	23d. Date of delivery Month Day Year
3	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	co use contribute to the cause of death?
1 Yes 2	No 3 Probably 4 Unknown  24b. Were autopsy findings available
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e Did tobacc   1   Yes   2	prior to completion of cause of death?
1 ✓ Yes 2 1 1 ✓ Yes 2 2 1 1 ✓ Yes 2 2 2 1 1 ✓ Yes 2 2 2 2 2 2 2 2 2 3 2 3 2 3 2 3 2 3 2	No 1 Yes 2 No
28. Place of Leving Alley  28. Place of Leving A	idence 6 🗹 Other: Scene
28d. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how in part year)  28d. Describe how in part year  28d. Describe how in part year)  28d. Describe how in part year  28d. Describe how in part year)  28d. Describe how in part year  28d. Describe how in part year)	injury occurred o to fixed object collision
Description of the particular	et and Number or Rural Route Number, City
Se agrantia in the second of t	, Chevy Chase, MD
Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 5810 Connecticut  1	
Here the second of the cause (s) is the second of the cause (s	d. Date signed (Month, Day, Year)
Panulo Frenchall, MD O.C.M.E. A.	ugust 1, 2012
30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	3
State 31. Date filed (Month, Day Year)  32. Register's Signature	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HELEN 11:04 PM STEAGAL 2012 AUGUST Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) unk 1 🗆 M 2 🖾 F Months Hours Feb 4, 1965 **Director** 214-82-4408 47 Usual Residence of Decedent 28a-f show e filed within 72 hours after death with the Maryland tal Hygiene. other than "natural", or items 23a or 28a-f shore other than "natural", or items be notified at event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1 🗆 Yes 2 🏝 No 10f. Zip Code 21230 10e. Street and Number Citizen of What Country? 2513 Sidney Avenue Funeral 12. Was Decedent Ever in U.S. un 3. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11, Marital Status unk 14. Race - American Indian, Black White etc þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry UNK (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ٥ Barbara James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2818 Waterview Avenue; Baltimore, MD 21225 Barbara James - mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☒ Other (Specify) in state Signator of uneral selectionsee S. Ward., 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death BRAIN disease or condition MASSIVE EMBOLISM Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) executed the attending physician and the for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 Unknown 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute Renal Failure Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has performed? Yes 2 No 2 🗌 No 1 Tes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Resident RESOUT AUGUST 03 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. Hancver St. Baltimore, Maryland 21225 Margo Jordan State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Marylan				Mental Hyg	jiene	
			State Registrar		Cer	tificate of D	eath		Reg. No. 2	2 2567
Ī	Physicia Medic		1. Decedent's Name (First, Middle, Last)	loyce	T	rent		2. Date of Dea Month August	Bay Year	3. Time of Death
1	Examir	ner	4a. Facility Name (if not institution, give stre	eet and number)	1	4b. City, Town, or	Location of Death	City	4c. County of De	ath
	Funeral Director			7. Age (In yrs. I	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 27	Year) C	irthplace (State or Foreign ountry) st Virginia
	yland f show ed at	tot	Usual Residence of Decedent  10a. State  10b. County	10c. Cit	y, Town or Loc	ation			, -, -, -, -, -, -, -, -, -, -, -, -, -,	10d. Inside City Limits
	e Mar r 28a- notifi	Sire	WV Greenbrie	er R	Ronceve	rte 10f. Zip Code				1 Yes 2 X No
	h with the is 23a o	Funeral Director	Rt. 2 Box 160			24970	)		10g. Citizen of What C	ountry?
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	. Was Decedent Ever in U.\$ Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	lf lf	Vas Decedent of His Yes, specify Cubar ☐ Yes 2█ No	n, Mexican, Puerto		14. Race - Am Black, Wh Specify: W	
21215-0036	hin 72 hou ne. than "nat e Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give k life, DC	ent's Usual Occupa ind of work done d O NOT use retired)	uring most of wor	king	16b. Kind of Busines:	,
	ed wit Hygie other i	Be C	12 17. Father's Name (First, Middle, Last)		Line	Superviso		ne (First, Middle, M	Electroni	cs
Maryland	should be filed within 72 n and Mental Hygiene, 7 is marked other than "raumatic event, the Med	읻	Seibert Ivan Weikle	:				la Morgai	,	
	and 2 shou Health and tem 27 is m		19a. Informant's Name/Relationship (Type, Michelle Glass	Print)		g Address (Street a Bpx 160			City or Town, State, 2	(ip Code)
Baltimore,	Page 1 ar nent of He ant: If iter ıry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ ponation 5 ☐ Other (Specify)	moval from State C	Place of Disposemetery, cremeters, Ce	sition (Name of atory or other place metery		Date 2-2012	20c. Location - City o	
Balt	permit. Page Department Important: I any injury o once.		21. Sunfure of Funeral Savice Licensee	d Q0		Name and Addres			an Funeral ria, VA 2	Service 2310
	Physician/		23a Part 1. Enter the disease, or complication of the complete shapes, or heart failure. List only one of the complete shapes or condition	ations that caused the death ause on each line.  Authorized Mediania				or respiratory arre	est,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a con lequ	uence of):					
	rted d ansit	Examine	Sequentially list conditions, if any bading a limited list. Cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse.)	ience of):					
0	ate be executed obysician and the burial-transit	edical Ex	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):					
3760	ificate ig phy as the		O.							
. Box 687	ie death certi the attendin ched for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)	/		23d. Date of d Month	elivery Day Year
ds, P.O.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trans.	by	Part II. Other significant conditions contri	buting to death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?  Probably 4 Unknown
Division of Vital Records,	<b>sician:</b> The law re certificate has be lirector, page 2 sh	Completed						24a. Was ar autops perforr 1 \(\sum \) Yes :	y prior to ned? death?	utopsy findings available completion of cause of es 2  No
/ital	ysician: is certific director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	pital:		Other	ce of Death (Chec			1
of \	ng Phys fter this ineral d	te: To	27. Manner of Death  1 Natural 5 Pending	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	at	ome 5 □ Reside 28d. Describe ho	nce 6 Other (Spe w injury occurred	cify)
sion	I or Attendin after death. Director: Aft I in by the fur	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho	me, farm, stre	M 1 □ \	∕es 2□No	28f. Location (Str	reet and Number or Ru	ural Route Number.
Div	oital or ours afte eral Dire	al Ce		building, etc. (Specify,				City or Town	, State)	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check 2 Medical Examiners only one) 3 Certifying Nurse P	n: To the best of my knowled On the basis of examination ractitioner: To the best of m	n and/or investi	gation, in my opinior death occurred at th	n, death occurred a e time, date and pl	t the time, date and	d place, and due to the	cause(s) and manner stated.
	vit To		29b. Signature and title of certifier	<b>J</b>		29c. License			9d. Date signed (Moni	
Ì	0 \		30. Name and address of person who com	pleted cause of death (Item	23a) (Type, Pr		Balk	more	M9212	P7
	Stat Registra		31. Date filed (Month, Day, Year)  AUG 1 3 2012	32. Registrar's Signat	ure					

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			For State	State of N	/larylan					and M	lental Hy	gien	е			-
			Registrar  1. Decedent's Name (First, Middle, La.	Certificate of Death						0 D-tf D-	Reg. No. 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2					
	Physicia		Richard B. Thra	_						2. Date of Death  Month  AUGUST  Day 8, 2012  3. Time of Death  9, 44 P M						
	Medic Examin		4a. Facility Name (if not institution, give							4c. County of Death					_	
	<i>;</i>		SAINT JOSEPH MEDICAL CENTER TOWSON									Ι,	BALT	me	RE	
	Funeral		5. Social Security Number 6. S 216-14-4935	ex 7. A	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr										ace (State or Foreig	ın
	Director		Usual Residence of Decedent	87 Yrs.				12/15/								
	ahov ahov	Į.	10a. State 10b. County	10c. City, Town or Location									10	d. Inside City Limit	s	
	I end 2 should be filed within 72 hours after death with the Maryland of Heatth and Mantel Hygiena. If Heatth and Mantel Hygiena. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at	Director	Maryland Baltimore Timonium											İ	1 ☐ Yes 2 1 N	lo
		alD	10e. Street and Number		10f. Zip Code 21093						10g. C	itizen of Wha	at Count	ry?		
		Funeral	200 Shahor Cy House								U.S.A.					_
(0		by Fu	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married			5. 13.	<ol> <li>Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,</li> </ol>				city Yes or No- Rican, etc.)		<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>			
8	rs aft	ed b	3 ☐ Widowed 4 ☐ Divorced	3140		1 ☐ Yes 2 ☑ No Specify:						Specify: White				
5-0	2 hou "natu	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work						st of working	16b. Kind of Business/Industry						
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d 2	ed wi Hygis other ent,	اما	9 Refurbisher  17. Father's Name (First, Middle, Last) 18 Mother's Name							e (First, Middle, Maiden Surname)					-	
a	ba fil antel rked ic ev	욘	Richard B. Thras		Mattie Ho											
ary	hould and M is mar									er or Rural	ral Route Number, City or Town, State, Zip Code)					_
Σ	permit. Paga 1 end 2 s Department of Haalth s Important: If Item 27 i any injury or other tra once.		Shirley Ann Thra	sher / dti	^		Chantr				onium,					
ore			20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐	Removal from State		lace of Dispe	osition (Name	e of ner plac	:e)	D	ate	20c. l	Location - Ci	ty or Tov	vn, State	
Baltimore, Maryland 21215-0036			4 ☐ Donation 👂 🖸 Øther (Speci		Hilltop Serv. Corp.							wson, Maryland				
Bal			21. Signatur & Figure Rervice Nicersee 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 21204									me, Inc.				
		Ш	23a, Part 1, Enter the disease or com	olications that cause	ed the death		050 Yo						anu Zi		A	-
	nysician/		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final									Approximate Interval Between Onset and Death				
	Medical		disease or condition resulting in death)  Onset and Death  Onset and Death  Onset and Death													
	Examiner	Examiner														
	_ =		Sequentially list conditions, if any, leading to him solute cause. Enter Underlying												·	_
	axacutad an and irlal-transit	xan	Cause (Disease or injury that initiated events c													_
		I I	-													
P.O. Box 68760	cata t phys s tha	edic		d												_
89	cartifi nding usaa	2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy							23d. [			Date of delivery			
ရွိ ရ	death e ette ad for	F FEMALE:   23b. Was decedent pregnant   1									Month Day Year					
0	Section   Sect													_		
σ.	as tha igned be da	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									d tobacco use contribute to the cause of death?					
Division of Vital Records,	alupar s naar blood	Completed									1 ☐ Yes 2 X No 3 [				ably 4 ∐ Unknow	n
တ္ထု	hes b	E D									24a. Was autoj	DSY	prio	r to com	y findings available pletion of cause of	
<u> </u>	n:Tha ficata or, pa	ပ္တို	25. Was case referred to medical			-		00 DI			1 Yes	2 X N	lo 1	Yes 2	! □ No	_
Vita Vita	Physician: The lav this certificats hes aral director, page 2	To Be	examiner?								ome 5 Residence 6 Other (Specify)					
<b>d</b>	og Phy neral		27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at								28d. Describe how injury occurred					
on i	endin eath. or: Aff the fu	Certificate:	1 Natural 5 Pending 2 Accident Investigation	<i>lay, Year)</i> injury work? M 1 ☐ Yes 2 ☐ No												
<u>Kisi</u>	ftar di ftar di lirect	Ě	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	jury - At hor c. (Specify)		eet, factory,	office		2	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
ָם ו	To the hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this o complataly filled in by the funeral di															
	24 hc 24 hc Fun Btaly	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												e(s) and manner stat	ed.
:	o the		29b. Signature and title of certifier 29c. License number									29d. Da	29d. Date signed (Month, Day, Year)			
			1	10			7	30	26	3	8-8-12 SON, MARYLAND 21204					
	11/1	Ì	30. Name and address of person who o	ompleted cause of	death (Item	23a) (Type, I	Print)		<i>y</i> • • •							_
1	, v		FRANCIS KHOO	, M.D.	760	1 OSL	ER D	RIL	15	Tows	ON, N	MAR	YLAN	D 2	1204	
	Stat Registra	•	31. Date filed (Month, Day, Year) AUG 1 3 201	2 Registr	ar's Sign	are far	Kar				·					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WitomsK Physician/ Month 2012 James Stanley 5:15 PM August Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Regional Hospital Prince George's Laure 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) **Director** 213-30-4694 1**x**xM 2 □ F Yrs. 78 01-06-1934 Maryland Usual Residence of Deced 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at Director 1 ☐ Yes 2X No MD Hanover Howard 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number 23a Funeral United States 21076 6471 Louden Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Black, White, etc. 0 1 Never Married 2 Married 1**X X**Yes 2 ☐ No If Yes, Give Year or Dates. ≥ 1957 Saltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2xx No Specify. Specify "natural", 3 Widowed 4 Divorced 1958 White Completed the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Credit Manager Retail 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be fill of Health and Mental if item 27 is marked မ Stanley J. Witomski, Sr. Martha Kerner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6471 Louden Avenue, Hanover, Maryland 21076 Mary L. Witomski - Wife other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 ō **±** cemetery, crematory or other place) Department or Important: If any injury or once. 1 X Burial 2 Cremation 3 Removal from State ō Atlantic Crematory 08-11-12 Glen Burnie, Maryland 4 Domatidn 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signati Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Nec MON disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Li Fetal 300.

Pregnant at time of death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? been signed by the atte should be detached for Month Day Year 2 No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 certificate has performed? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) Residence 6 \( \text{Other} \) Other (Specify) 2 🗹 No 1 Inpatient 2 1 Yes မ ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 28d. Describe how injury occurred Certificate: s after dea... 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined the Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 247 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohamed Tourky, MD Laurel Regional Hospital 7300 Van Dusen Road 20707 Laurel.

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WRIGHT MARGARET August 8 8:00 A Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Annapolitan Assisted Living Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 216-28-4043 **Director** 1 🗆 M 2 🕱 F 85 Usual Residence of Deced Julv 3. 1927 Maryland 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 🛣 No Anne Arundel Annapolis 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be items 23a Funeral 1429 Hunting Wood Road 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. DOD 8/8/2012 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ò by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Hygiene. other than "natural", Completed 3 ☑ Widowed 4 □ Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 other t Cardiac Technician <u>Johns Hopkins Hospital</u> traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o Harry Eugene Wilson Angela Pauline Kehoe Page 1 and 2 should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Louisa Troutner / daughter 1429 Hunting Wood Road; Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Margaret 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 8/10/2012 4 Donation Towson, MD Other (Specify) permit. <sup>22. Name and Address of Facility</sup> Ruck Towson Funeral Home, Inc 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. MEA disease or condition Medical resulting in death) **Examiner** unknown Sequentially list conditions Examiner If any leading to immediate cause. Enter Underlying the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death s after death. 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier сопріветь only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) Dhawan, MD 8 9 2012 10062534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RITA DHAWAN, MD 9055 Chevrolet & Suit 103, Ellicelt Gty DV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Dariene Denise W	1-For State 1-For State Certificate of Department of Pickets Registrar		Reg. No. 2012 256
Physician/ Medical Examine	Decedent's Name (First, Middle, Last)	Mon	of Death th Day Year
Examile		July  City, Town, or Location of Death	20, 2012 1635 hrs
. A	·	timore	N/A
Funeral Director			te of Birth (MW/DD/YYYY) 9. Birthplace (State or Foreign Country) ND
Maryland 28a-f show any datonce. ector	10a State 10b. County Baltimore Baltimore		10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f sh notified at once al Director		f. Zip Code 21218	10g. Citizen of What Country? USA
Lhours after death with "natural", or items 22 Examiner must be in ted by Funeral	2 Midward A Dispressed Wyon Chra Veny	cedent of Hispanic Origin? (Specify Ye specify Cuban, Mexican, Puerto Rican, e	
Se man Se	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 2 th  N/A  16a. Decedent's Us during most of the completed of the completed of the completed of the complete o	sual Occupation (Give kind of work done if working life. DO NOT use retired) S Assistant	16b. Kind of Business/Industry Assistant Living Home
MD 21215-0036 of 2 should be filled within 7 lith and Mertal Byggiene in 27 is marked other than animatic event, the Medical To Be Comple	UNKNOWN	_	ane Scott
MD 21 nd 2 should alth and Me m 27 is ma aumatic ev	Dekersia Surrivan/Daughter 124 N.		41431
Baltimore, MD 21215-005 pernt. Pages I and 2 should be filed with Department of Health and Mertal Hygiene Important: If them 27 is marked other thingury or other traumatic event, the Mediumy or other traumatic event, the Medium To Be Comi	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify	##atory   8/4/12	
	2/00	Edmondson Ave.	y D. Cromartie F/S Balto., MD 21223
Physician /Medical Examiner	23a. Part Enter the disease, or complications that caused the death. Do not enter the mod failure. List only one cause on each line.  Immediate Cause (Final disease a Narcotic and Alcohol In		ry arrest, shock, or heart Approximate Interval Between Onset and Death
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):		
ted nsit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		
7 0 6	I O	me. 0930 8-14-12 (	2m
2 5 5 6 2	IF FEMALE: 23c. If yes, outcome of pregnancy	ше, д э э о т ч т г з	23d. Date of delivery
). Box 687 the death certific by the attending I ched for use as th	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal de 4 Pregnant at time of death 5 Other (	ath 3 Ectopic pregnancy  Specify)	Month Day Year
P.O. B so that the degree by the detached I by Phy			Did tobacco use contribute to the cause of death?
ords, P w requires the strong signs should be d			Yes 2 No 3 Probably 4 X Unknown  Was an 24b. Were autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requires rs after death.  **IDirector: After this certificate has been signed in by the funeral director, page 2 should be retification: To Be Completed		1 🔀	autopsy prior to completion of cause of death?  Yes 2 No 1 X Yes 2 No
ital Recician: The scertificate rector, page	25. Was case reterred to medical examiner?	26.Place of Death (Check only one)	
n of Vi IngPhysi After this funeral du	1 X Yes 2 No Impatient 2 X EN Outpatient 3 27 Manner of Death 28a Date of Injury 28b Time of Injury		5 Residence 6 Other:
ision Attendin r death. rector: A by the fur	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation fd 7-20-12 fd 3:48 p	m 1 Yes 2 x No unkn	IOWD
Division o Division o Bioprial or Attending 124 hours after death. Fruncral Director: Aft etcly filled in by the fun call Certification:	3 Suicide 6 X Could not be 4 Homicide 6 X Could not be determined (Specify) Fd: Private Dwell	tory, office building, etc. 28f. Locating	ation (Street and Number or Rural Route Number, City Fown, State) <b>2705 Matthews St.</b>
To the Ho To the Fu To the Fu completely	Check only  Check only  Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurred at the time, o	date and place, and due to the cause(s)
2	29b. Signature and title of certifier	29c, License number O.C.M.E.	29d. Date signed (Month, Day, Year)  July 21, 2012
.0		re Street, Baltimore, MD 21223	3
State Registrar			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ July 2012 Year Miriam S. Allgaier а м 7:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Columbia Lorien Nursing Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Min **Director** 057-26-7478 102 1 □ M 2 🛣 F 02/15/1910 NY 28a-f shov 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Howard Ellicott City 1 ☐ Yes 2 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21043 4107 Sears House Court United States ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Dentist Dental Hygentist Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Demler Harry Swartwout and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4107 Sears House Court Ellicott City, MD f Health a item 27 i Linda M. Keldsen - Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cremation Center of MD07/28/12 Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final bulmonery metastes swith Physician/ disease or condition resulting in death) Medical 24% Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): inbeles 10.423 the attending physician and thed for use as the burial-trans that initiated events resulting in death) Last Physician/Medical certificate be P.O. Box 68760 " use a IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery es, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 1 ☐ Yes 2 ₺ 9 ☐ Unknown Unknown á. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ate has page 2 s performed? this certificate 2 🗌 No Yes 2 No 1 🔲 Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. I Director: After the Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D 34 97 44 c Prightario July, 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHARL MEHTA, MD 8775CLOUDLEAP CT, # 224, COLUBIA, MD 2104-5-31. Date filed (Month, Day, Year) JUL 3 0 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P M Ju<sub>1</sub>v 26 2012 6:00 <u>Harold</u> Lloyd Barlekamp Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mary's Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Age (In yrs. last birthday) **Funeral** Months Days Hours (Month, Day, Year) 03/23/1930 Director 285-24-8563 82 Ohio Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2 🕅 No Charles White Plains Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20695 USA 4210 Southwinds Place, Apt. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married ģ 1 X Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Battery Industry Factory Worker traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Should be file and Mental F ၉ Earl R. Barlekamp Mary Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. 6905 Pale Morning Ct., Hughesville, MD 20637 Myra L. Stalnaker/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Mem.Gardens/Knollcrest 8/01/2012 Arcadia, Ohio 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signature of Funeral Service Licenses 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line set and Death Immediate Cause (Final AIZHEIMERS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last xaminer Due to (or as a consequence of): burial-transit Due to (or as a consequence of): lω attending physician for use as the buria Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No as been signed by the 2 should be detached 9 Unknown P.O. Part II. Other significaryt conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, has been DEPITENSI STY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an BACK PAIN page performed? Yes 2 No MONIC certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25, Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury accurred iniury 1 Natural 5 Pending М 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2062

d cause of death (Item 23a) (Type, Print)

32. Pégis rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jul v 2012 Douglas Maxwell Bivens, Jr. 26 03:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In vrs. last birthday) 216-30-3032 Director 1 🗶 M 2 🗆 F 10-13-1929 Maryland 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗌 Yes 2 🙀 No Calvert Huntingtown 0 10e. Street and Number 10g. Citizen of What Country? 20639 USA 1850 Emmanuel Church Road Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 N No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Calvert County Elementary/Secondary (0-12) College (1-4 or 5+) Educator Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Douglas Maxwell Bivens, Sr. Luella Dowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Daryl K. Bivens, Son 4700 Duley Drive, White Plains, MD 20695 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 07-27-2012 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. William R. Grow M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Atheroscienotic ardibuscular disease disease or condition resulting in death) Medical Examiner Cardio vacular disease Hypertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Congestive Heart Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Chronic Icidney disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Fibrilla tion Atricil 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the Within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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Registrar DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registra's Signature

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7-25-2012

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25685 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2012 Physician/  $J_{uly}^{\text{Month}}$ Billy Blankenship 25, 5:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Charlotte Hall Veterans Home Charlotte Hall Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Days Hours 0370871926 West Virginia 86 **Director** 236-36-0274 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Calvert Solomons 1 Yes 2 XNo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 20688 United States 14346 Sedgewick Ave. "natural", or items? edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1X Yes Black, White, etc. 1 Never Married 2 Married ģ 1**X** Yes 2 □ No. If Yes, Give 1946–1954 Year or Dates. Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: Specify: 3 X Widowed 4 □ Divorced Completed le 1 and 2 should be filed within 72 hour t of Health and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homes and Boats Painter 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ollie Lunsford Walter B. Blankenship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9217 Easy Street, Owings, Maryland 20736 19a. Informant's Name/Relationship (Type, Print) Barbara Martin - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 = 5 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or Metropolitan Crematory 7-26-12 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licer 22. Name and Address of Facility P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each har Immediate Cause (Final Ph\_sician/ Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for se a conesquence of the attending physician and thed for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Dav Year Pregnant at time of death 9 🗌 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 16R4 DIS EASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has URG performed 2 🗌 No AIL Yes 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and 437228mD person who completed cause of death (Item 23a) (Type, Print)

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State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registra Signature

JUL 26 2012

Stephen Cafferty, MD 100 Hospital Road, Prince Frederick, MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ July 13, 14:18 P M Franklin Beale Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex If Under 1 **Funeral** Days Months Min Hours Director 223-06-2590 1 X M 2 D F Yrs. 66 1945 31, Virginia Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be Funeral 1727 Montana Avenue NE 20018 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1 X Yes 2 ☐ No Black, White, etc þ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 Black 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4 or 5+) Miller Long should be filed with and Mental Hygien 7 is marked other th Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Department of Health and Ment.
Important: If item 27 is marked any injury or care. Charlie Beale Nettie Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Jones - Daughter 1727 Montana Avenue NE Washington, DC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Lee's Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2012 Clinton, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Service Licenses M00560 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final RESISTANT Physician/ ULTIDRUG disease or condition Due to (or as a consequence of) Medical resulting in death) **Examiner** WIRATOR) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ENTEROCOCCUS INFECTION the burial-trar resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ signed by the atte in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s After this certificate has autopsy perform death? Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 ျ 1 Tes 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred Hospital or Attending I 24 hours aller death. injury Natural Natural 5 Pending Accident Investigation To the Funeral Director completely filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the I 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

only one) 29b. Signa

me and address of person who completed car

DHMH 17 Rev 06-2011

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death (Item 23a) (Type, Print)

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Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 ay Physician/ 2012 John Henry Burton July :21 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Union Hospital of Cecil County E1kton Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours March 21 Min 17 M 2 1 218-40-7730 69 1943 Director Maryland Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Examiner must be notified at Director 28a-f 1 X Yes 2 No Maryland Cecil Elkton 10f. Zip Code 10g. Citizen of What Country? 6 10e. Street and Number 23a Funeral 21921 54 Elk Chase Drive items 12, Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. 0 2 1 XNever Married 2 Married iled within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: i and 2 should be filed within 72 hours aft f Health and Mental Hygiene. item 27 is marked other than "natural", 3 Widowed 4 Divorced White Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Homestead Publishing Elementary/Seconday (0-12) College (1-4 or 5+) Belair, Maryland Twelve Years Printer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) R. Anna Smith George H. Burton 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2709 Ferris Road, Wilmington, Delaware 19805 Julie Ann Edwards (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place, West Chester 1 Burial 2 Cremation 3 Removal from State 07/22/12 Pennsylvania 4 Donation 5 Other (Specify) R.A.Ferris & Co., Inc. 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A.

Maryland 21903-0766 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line intracranial Immediate Cause (Final Hemorrhal Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of anding physician and use as the bunal-transit that initiated events CERTIFICAT Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ has been signed by the atter second be detached for u in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L g Unknown 2 🗌 No g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Records, has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 X N page 1 ☐ Yes 2 X No After this certificate To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check з 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) only one, \_ 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD D0062190 q 21915 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVIT Shahnawaz Khan, M.D., 2533 Augustine Herman Hwy., Suite A, Chesapeake City, MD 31. Date filed (Month, Day, Year UL 23 Registrar's State backer Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JűIÿ 30<sup>pay</sup> 2012° 10:15 AM Robert O. Brunner Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Vantage House Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In vrs. last birthday) Days Hours 294 18 8265 **Director** 1X M 2 | F 12/06/1922 Ohio 89 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral should be filed within 72 hours after death with and Mental Hygiene. 5400 Vantage Point Road #313 21044 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ō 1 Never Married 2 X Married þ 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Completed Year or Dates. 1942-46 White ge 1 and 2 should be filed within 72 hours it of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Economist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Otis F. Brunner Grace Hirsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5400 Vantage Point Road #313 Columbia, MD 21044 Olga L. Brunner/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Cremation Cntr of MD 7-31-2012 | Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. all MOL044) 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final netastalic Cholangio Carcinoma Physician. disease or condition Medical resulting in death) Examiner Obstruction Sequentially list conditions if any, leading to immediate cause. Enter Underlying Exami requires that the death certificate be executed Cause (Disease or injury that initiated events -trar and Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 ☐ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s after death.

I Director: After this certificate has 1 Yes 2 No Yes 2 XN or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital Other 2**X** No ျှ 1 U Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending iniury 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral E Hospital Medical 29a. Certifier 1 🔀 Certifying Physîcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 50) anneh D3064 July 31, 2012

5+ State

Registrar DHMH 17 Rev 06-2011

Kamesh 31. Date filed (Month, Day, Year) ESSPX MD 21221.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ramesh Sabapathi 201-109 Back River Neck Road

201-109

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🔝 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Clifford M. Beach 0335 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HICOMICO Regional TENINSHLA Ceater SAL13BURY If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Hours (Month, Day, Year) **Director** 220-32-2274 1 🛛 M 2 🗆 F 77 Yrs. April 21, 1935 Delaware Usual Residence of Decedent 28a-f show 10b. County 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XX Yes 2 □ No Delaware Sussex Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Lincoln Avenue 19940 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 12 Insurance Agent Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uld be file Mental and Mental မ Department of Health and Ment: Important: If item 27 is marked any injury or care. Joseph I. Beach Lettie Melson Goslee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis T. Beach (Wife) 600 Lincoln Avenue Delmar, DE19940 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stephens Cemetery 107-28-2012 Delmar, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home Delmar. DE 13 East Grove Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DAVS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \Bigcap \) Nursing Home \( 5 \Bigcap \) Residence \( 6 \Bigcap \) Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) Ll1 OTE 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 06-2011

Registrar

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Henry 525 pm Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner KINS Baltimore more If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** (Month, Day, Year) 164-30-4187 Director 74 1 🛛 M 2 🗆 F July 31 1937 Pennsylvania Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No Penna. Franklin Greencastle 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? o "natural", or items 23a or Funeral 3531 Williamson Rd. 17225 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces' Black, White, etc by 1 Never Married 2 X Married 1 X Yes Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White 1960-62 Specify: 3 Widowed 4 Divorced Completed Year or Dates. er than "natura, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Banker Banking 12 and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ೭ John J. Bingaman Pauline Starliper Page 1 and 2 should I nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Nancy Bingaman/Wife 3531 Williamson Rd. Greencastle, PA 17225 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If is any injury or conce, cemetery, crematory or other place)
Geisel Funeral Home 1 Burial 2 🔀 Cremation 3 D Removal from State 8/4/2012 Chambersburg, PA 4 ☐ Donation 5 ☐ Other (Specify) And Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. Martin 45 S. Carlisle St. Greencastle, PA 17225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final REBNOVASCULAR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury Examine Due to for exily normagisaring off -tran and that initiated events resulting in death) Last Due to (or as a consequence of): the burialattending physician Physician/Medical that the death certificate be P.O. Box 68760 as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Pregnant at time of death the Unknown 9 Unknown þ been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Division of Vital Records, The law requires 1 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes Other: 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer (Month, Day, Year) work? atural 5 Pending 2 🗌 No M Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 2 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD. WO ORLEANS ST. 1800 2)mns 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

12-05765 Carl Conaway

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arl Conaway	State of Maryland / 1- For State Registrar	Department of Certificate of		al Hygiene Reg. 1	No. 201	2 2569
Physician/	Decedent's Name (First, Middle,Last)     Carl Joseph Conaway, Jr.	<del></del>		2. Date of Death Month Da	av Year	3. Time of Death
ledical Examiner	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of I	August 2, 20	12 4c. County of Death	
	Upper Chesapeake Medical Center		Bel Air		Harford	
Funeral	5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year   If Under 2 Months   Days   Hours		MM/DD/YYYY) 9. Birth Foreign	
Director		.6 Yrs		Min. 7/28/1	966 Cour	ntry) DE
any	Usual Residence of Decedent  10a. State 10b. County 1	Oc. City, Town or Locati	on			10d. Inside City Limits
	DE New Castle	New Castle	9			1 Yes 2 X No
auth with the Maryland items 23s or 28s-f show ust be notified at once, inneral Director	121 Stann Boulevard		10f, Zip Code 19720	10g.	Citizen of What Count USA	ry?
T S C	11. Marital Status  1 Never Married  2 Married  12. Was Decedent E Armed Forces?  1 X Yes 2  3 Widowed  4 Divorced If Yes, Give Year	No If Y	Yes 2 X No specify:		14. Race - America White, etc. Wh	an Indian, Black, ite
ours aft attural" camine	or Dates: 6  15. Decedent's Education (Specify only highest grade comp	eted) 16a. Deceden	t's Usual Occupation (Give kir		b. Kind of Business/In	
5-1036 ed virtin 72 hour lygiene diver than "natu the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+	Mechai	ost of working life. DO NOT us N <b>iC</b>	r	orklift Eq	
OO3	12 17. Father's Name (First, Middle, Last)		16.Mothar's	Name (First, Middle, Maid	ervice Pro	viaer
21215-()036 und be filed within 7 Mental Hygiene. marked other than to event, the Medica FO Be Comple	Carl Joseph Conaway, Sr.		Rober	cta M. Rose		
MD 21 nd 2 should lith and Mer m 27 is mar aumatic ev	19a. Informant's Name/Relationship (Type, Print ) Deborah Cochran Wife	19b. Mailing	Stamm (Street and Number Stamm) Stamm	er or Rural Route Number cd, News Cas	r, City or Town, State, 3 Stle, DE 19	Zip Code) 1720
Te, I and I and Health	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State		ition (Name of cemetery, ner place)	Date 20	Oc. Location - City or T	own, State
Pages nent of	4 Donation 5 Other Specify:	St. Georg		8/8/2012 S	St. Georges	, DE
Baltimore, permit. Pages 1 ar Department of Hee Important: Uf the Important: Uf the Impury or other tr	21. Signature of Funeral Service Licensee		ame and Address of Facility	Daniels & H		
Physician	23a. Part I. Enter the disease, or complications that caused the	he death. Do not enter the	me, LLC, 212 None mode of dying, such as care	diac or respiratory arrest,	shock, or heart	Approximate Interval
/Medical	failure. List only one ause on each line.  Immediate Cause (Final disease a. Atheros	sclerotic C	ardiovascular	Disease		Between Onset and Death
Examiner	or condition resulting in death)  Due to (or as a consequence)					
-A	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a conseq	Quence of):			·	
ed nsit <b>Examiner</b>	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a conseq	weens of):				
uted id ansit	events resulting in death) Last Due to (or as a conseq d.	querice or).				
t0, e be executed ysician and burial - transit	▼ UNPENDED ★ AMENDED 10d,	10e,19b,pe	r fh,g930 8-13 1,27 per me g9	3-12 sm	v+	
760 icate b g physi the bu	IF FEMALE: 23c. If yes, outcome	e of pregnancy			23d. Date of delivery  Month Da	y Year
Box 6876( e death certificate the attending phys ed for use as the b hysician/Me	past 12 months?	me of death	tal death   3	regulaticy	MOUL	iy leai
he death certificat the death certificat the attending phy ched for use as the Physician/W	1 Yes 2 No 9 Unknown 9 Unknown					(1.00)
P.C es that igned I go deta	Part ii. Other significant conditions contributing to death t	but not resulting in the u	nderlying cause given in Part		cco use contribute to the No 3 Proba	
ords. w requir				24a, Was an autopsy	prior to co	ppsy findings available mpletion of cause of
Reco The law icate has page 2 s				performer 1 ✓ Yes 2	d? death? No 1 ✔ Yes	2 No
tal Recision: The certificate rector, page	25. Was case referred to medical examiner? Hospital: 1 Inpution		26.Place of Death (C		:d	
of Violog Physical After this uneral dir	1 V Yes 2 No 1 Inpatient  27. Manner of Death 28a. Date of Injury (Month, Day, Yes	t 2 ER/Outpatient y 28b. Time of I		Nursing Home 5 Res	sidence 6 Other:	
ion of tending Pt eath.  to After the funeral the funeral ation: T	Natural 5 Pending	ar)	1 Yes 2 N	lo		
Division of Vital Records, spital or Attending Physician: The law requirements after death.  Including the funeral director, page 2 should to Certification: To Be Complete:	3 Suicide 6 Could not be	ıry - At home, farm, stree	et, factory, office building, etc.	28f. Location (Stree or Town, State	et and Number or Rura	al Route Number, City
Di spital nours a filled	4 Homicide determined (Specify)					
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the  Medical Certificati	29a. Certifier 1 Certifying Physician: To the best of my one)  2 Medical Examiner: On the basis of examiner	knowledge, death occur ination and/or investigat	red at the time, date and place ion, in my opinion, death occu	e, and due to the cause(s) irred at the time, date and	) and manner as stated I place, and due to the	i. cause(s)
To 1 with To 1 com	and manner stated.  29b. Signature and title of certifier		29c. License number		9d. Date signed (Mont	
	with		O.C.M.E.	A	August 3, 2012	
	30. Name and address of person who completed cause of dea					
	Ling Li, MD Assistant Medical Examiner		re Street, Baltimore, MI	D 21223		
State		Signature				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ 2330 Richard Loring Cunningham Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HICONICO TENMSULA 9. Birthplace (State or Foreign . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Numbe **Funeral** Days Hours Country) Min. Director 089 26 5983 78 1 □**x**M 2 □ F 12/20/1933 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 24 No MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 23a USA 48 Cresthaven Dr. 21811 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black. White, etc. 1 Never Married 2 X Married Yes 2 XNo ģ Specify: white Maryland 21215-0036 1 ☐ Yes 💥 No If Yes, Give 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Hote1 Doorman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Constance Roman Martin Cunningham t, Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 Cresthaven Dr. Berlin, MD 21811 Lorraine A. Cunningham (wife) 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State injury or Department or Important: If any injury or Charles Cemetery 7/31/12 Farmingdale, NY 4 Donation 5 Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Fun 108 William St. Berlin, MD 21811 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying as the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No After this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. the funeral director, 24 hours after death. Funeral Director: A filled in by within 24 hound to the second To the I

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cent 7-24-2016

30. Name and address yho,completed cause of death (Item 23a) (Type, Print) HILhite, M.O. 100 € CAKROII

6 Could not be

determined

SP4136414

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

State Registrar

Medical

3 Suicide
4 Homicide

31. Date filed (Month, Day, Year) 32. Registrar's Signature,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20 12 Physician/ July AM 12:33 22 Rodell H. Cooper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's ManorCare Largo Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours **Director** 242-42-2083 1 M 2 XF Yrs 78 Oct. 20, 1933 Virginia Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No Waldorf Prince George's Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 20603 2955 Fern Hill Place "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify. Specify 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th Private Consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I မ Martha Scott George Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. <u>Venus Cooper-Tillman</u>/ Daughter 2955 Fern Hill Place Waldorf, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State July 28. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Waldorf, Maryland Heritage Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. Stener M00560 4001 Benning Road NE Washington, DC 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Onset and Death Immediate Cause (Final Ph. i. ian Cancer of Lung with Brain and Bone Metastasis disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown Month Dav Year signed by the and be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown been sig should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 🗌 Yes 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛂 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident I Director: A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) title of certifie 29b. Signature 07-25-2012 D 5 1520 45m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20032 1328 Southern Avenue SE Washington, DC Baharam Pishadad, MD

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month,

3 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vear 11:50 P.M oan 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOPKINS Johns HOSPITAL Baltimore . Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 213-60-0135 **Director** 1 □ M 2 😾 F 63 Feb. 1, 1949 Maryland Usual Residence of Deced 23a or 28a-f show ist be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Edgewood Harford Maryland 10f. Zip Cod 10g. Citizen of What Country? Funeral 21040 1300 Apple Ridge Court Examiner must U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ted Hygiene.
ad other than "natural", or ite Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced **Black** Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life, DO NOT use retired) Aberdeen Proving Ground Elementary/Secondary (0-12) College (1-4 or 5+) Claims Examiner Aberdeen, Maryland Twelve Years permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatic traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Calm Helen Marie Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean L. Hockaday 1300 Apple Ridge Court, Edgewood, Maryland (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/28/12 Darlington, Maryland Berkley Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final etroperitone Physicalists disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown ed by the a 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No has certificate 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 은 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this funeral 27. Manner of Death 28c. Injury at work? 1 □ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: After t 1 Natural 5 Pending eral Director: A 2 🗌 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number RES-000 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

SHIEL

FLIGENIE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

1800 N. Orleans St. Baltimore MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20 Physician/ July 2012 18:15 №M Amos Combs Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** July 19,1929 1 XM 2 - F Months Hours West Virginia 83 234-40-8722 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a State "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 X Yes 2 No Maryland Ceci1 Perryville 10e. Street and Number 10f, Zip Code 10a. Citizen of What Country? Funeral 21903 United States 350 Broad Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11, Marital Status Armed Forces?

1 2 Yes 2 No Army Black, White, etc. <u>^</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖁 No Specify If Yes, Give Year or Dates, 1952-54 Completed 3XXWidowed 4 □ Divorced of Health and Mental Hygiene. Hem 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Security Guard Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Jennie Tabors Andy Combs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 36 Bristol Way, Lewes, Delaware 19958 Linda Wortham / Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Ju1<sup>Date</sup>24 2012 o. ∓ .º Northy Easty Undered Methodist Cemetery X Burial 2 Cremation 3 Removal Important: It any injury or North East, Maryland 4 Donation 5 Other (Specify, 22. Name and Address of Facility Crouch Funeral Rome, P.A. al Ser 21. Sign 127 South Main Street, North East, Maryland21901 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease shock, or heart failure. L only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine If any, leading to immediate cause. Enter Underlying Cigo to for exit nonsequents of the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events Due to (or as a consequence of) resulting in death) Last anding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 4 Pregnant : Pregnant at time of death signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has be lirector, page 2 s autopsy perform death? 1 Yes 2 No 1 Yes 2 No neral Director: After this certification filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be Hospital: 2 🕡 No 1 Yes 1 Inpatient 2 PER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) iniury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) -43825

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12-05431

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<b>4</b> 31	Please	Type or Print in Black Indelible Ir	nk. Ensure All Copies Are Legible.		
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imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene.  tant: If item 27 is marked other than "natural", or items 23a or 23a-f she or other traumatic event, the Medical Examiner must be notified at one or other traumatic event, the Medical Examiner must be notified at one	]≏	19a. Informant's Name/Relationsh											ate, Zip Code)
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/Medical Examiner		failure. List only one cause of Immediate Cause (Final disease	on each line. a. Thermal B	urns and Mu	ultiple Blunt I	orce l	njuries						Between Onset and Death
Examiner	1	or condition resulting in death)	Due to (or as	a consequence	of):		-				•		
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risic r Atte ter dea irecto n by th	ICati		tigation 28e. Plac	ce of Injury - At I	nome, farm, stree	et, factory	, office bu	uilding, etc.	. 281			Number or	Rural Route Number, City
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10		Russell Alexander MD.	Assistant N	Medical Exa		W. Bal	timore	Street, E	Baltimore	e, MD 21	223		
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State of Maryland / Department of Health and Mental Hydiene

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900	ified within 72 hours after death with the Maryland tral Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent E Armed Forces? 1 Never Yes 2 Figure 1; Yes, Give Year or Dates.	No 1944	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 😿 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America k, White, e	
21215-0036	rithin 72 hou iene. r than "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5	(Give i	dent's Usual Occupa kind of work done d DO NOT use retired) get Analys	uring most of worki	ing	16b. Kind of Bu		ustry
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Baltimore,	permit. Page 1 and Department of Heal Important: If item 3 any injury or other once.		20a. Method of Disposition 1 ☐ Burlal 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Kent Crer	osition (Name of matory or other place mation Sei	٠ .		20c. Location - Smyrna,	,	wn, State
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Ò	Physician/ Medical Examiner		Due to (or as	the death. Do not enter.  The state of the s	or the mode of dying	g, such as cardiac o			2	Approximate Interval Between Onset and Death
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	icate be executed 3 physician and as the burial-transit	sal Exar	Cause (Disease or injury that initiated events c. Due to (or as a resulting in death) Last	a consequence of):						
8760	.5 20 21	Medic	IF FEMALE:							
. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as to	Physician/Medical	23b Was decedent pregnant 23c. If yes, outcome	2 Fetal death 3	Ectopic pregnance Other (specify)	у		23d. Date Mor	e of delive	ry Day Year
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/ita	sician: certific director,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 posti	ent 2 🗆 ER/Outpatier	Otho	r: A Number 110	only one) me 5 🗆 Reside	6 🗆 044	. (0/5.)	
on of \	nding Phy ath. r: After this ie funeral c	Certificate: To	27. Manner of Death  1 M Natural 5 Pending (Month, Day) 2 Accident Investigation	ry 28b. Time of	f 28c. Injury work	at	eme 5 $\square$ Reside 28d. Describe ho			
Division	tal or Atters after de al Directo		3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injubuliding, etc.	ury - At home, farm, stro c. (Specify)	reet, factory, office		28f. Location (Str City or Town		r or Rural i	Route Number,
	n 24 hou n 24 hou e Funer	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of only one) 3 Certifying Nurse Practitioner: To the	xamination and/or invest	stigation, in my opinio	n, death occurred at	the time, date and	d place, and due	to the cau	se(s) and manner stated.
	withi com		29b. Signature and title of certifier A	The w.	29c. License	OUY 1S		9d. Date signed	/	ay, Year)
	HAILIN		30. Name and address of person who completed cause of d Helen A. Noble, M.D. 122	eath (Item 23a) (Type, F 2 Speer Rd.	· Chestert	town, MD	21620	,		
4	Stat Registra		31. Date filed (Month, Day, Year) 32. Registra	ar's Signature						

		Funeral Home CCHD Please Type or Pr	rint in Black Inc	delible Ink	Fnsure All (	Copies Are I	eaibl	e.	
Tyler Ralph Dav			/laryland / Depai		lealth and Mer		-0 <b>3</b>	201	2 2569
Physicia	an/	Registrar  1. Decedent's Name (First, Middle,Last)	Cen	nicale of D		2. Date of	Reg. No Death	·	3. Time of Death
Medical Exami		Tyler Ralph Davis				Month July 28	Day 012	Year	0713 hrs
		4a. Facility Name (if not institution, give stree	et and number)	4b.	City, Town, or Location			c. County of Death	
		S/B Route 4 and Lower Pindell	Road	L	othian			Anne Arundel	
Funeral Director		5. Social Security Number 8.368 6. Sex 1 M M	7. Age (In yrs. last		f Under 1 Year If Und Months Days Hour	n Adin	f Birth (MM 14/19	7/DD/YYYY) 9. Birt Foreigi 93 Cou	
		Usual Residence of Decedent							
w any		10a. State 10b. County		Town or Location					10d. Inside City Limits  1 Yes 2 X No
ɗaryland <b>28a-f show</b> <b>i at once.</b>	ţ	MD Calvert  10e. Street and Number	Dur	nkirk	7. 7. 0. 1		140. 07		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	I Director	12631 Southern Mary		ard	0f. Zip Code 20754		Uni	izen of What Coun Ited Stat	es
th wit	uneral		Was Decedent Ever in U.S Armed Forces?		ecedent of Hispanic Ori specify Cuban, Mexicar			<ol> <li>Race - Americ</li> <li>White, etc.</li> </ol>	an Indian, Black,
er dea	Ē	3 Widowed 4 Divorced If Yes,		1 V	s 2 X No specify			Specify: Whi	ito
rs afte	þ	15. Decedent's Education (Specify only high	tes:		Jsual Occupation (Give		116b.	Kind of Business/Ir	
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215 be fil, rked ent, t	Be	Ralph Lawrence Davi			Li	sa Marie (	Cary		
MD 21215-0036 and 2 should be filed within 7 lith and Mental Hygiene. m 27 is marked other than aumatic event, the Medica	ဥ	19a. Informant's Name/Relationship (Type, P			dress (Street and Nu				
MC 2 st oil the am		Lisa Tenney / Mothe			outhern Maryl				
s l an ff Hea		20a. Method of Disposition  1 Burial 2 X Cremation 3 Re		ace of Disposition ematory or other	n (Name of cemetery, place)	Date		Location - City or	
Page Page nent control		4 Donation 5 Other Specify:	Lee	e Cremato		08/04/2012		linton, l	
Baltimore, permit. Pages I an Department of Hes Important: If lee	ı. İ	21. Sign e o Fune e icensee	2//		e and Address of Facilit				
	11	Lisa M. Mounts	10		00 Jennife			-	
Physician /Medical		23a. Part I. Enter the diseale, or complication failure. List only one cause on each line		Do not enter the n	node of dying, such as o	cardiac or respiratory	arrest, sh	ock, or heart	Approximate Interval Between Onset and
Examiner			ple Injuries (or as a consequence of)						Death
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ted J ansit	ш ј	events resulting in death) Last Due to d.	(or as a consequence or).						
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OX 68760, eath certificate be ext attending physician for use as the burial -	Med		. If yes, outcome of pregna				23	d. Date of delivery	
Box 68760, e death certificate b the attending physical for use as the bu	an/N	3b. Was decedent pregnant in the past 12 months?	Live birth	2 Fetal o	death 3 Ectopi	ic pregnancy		,	ay Year
ox 6 ath ce attend attend or use	Sici	1 Vos. 2 No. 9 Hakasus	Pregnant at time of dea	th 5 Other	(Specify)		.		
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ords, w require us been sign should be	ted					1 24a. V	Vas an	i 24b. Were aut	opsy findings available
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Division of Vital Records, tal or Attending Physician: The law require is after death.  al Director: After this certificate has been si led in by the funeral director, page 2 should b	B	25. Was case referred to medical examiner?			26.Place of Death	(Check only one)  Nursing Home 5	□ pid	0 400	0
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Sion	cat	2 Accident Investigation	8e. Place of Injury - At hor	ne, farm, street, fa		area	on (Street a	and Number or Rur	al Route Number, City
Divis pital or At ours after At eral Direct	Certification:	Suicide 6 Could not be	Specify) Major Road		g,	or Tow	m, State)	wer Pindell Roa	
Hospi 4 hou Funer		29a. Certifier 1 Cortifue Physician To	the best of my knowledge		at the time, date and pl	1			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	one) 2 Medical Examiner: On th	e basis of examination and	d/or investigation,	in my opinion, death or	courred at the time, of	late and pl	ace, and due to the	cause(s)
F. 2 5 8	Me	29b. Signature and title of certifier	THE STATE OF		29c. License number		29d.	Date signed (Mon	th, Day, Year)
		hinh is	•		O.C.M.E.		July	y 29, 2012	
		30. Name and address of person who comple	eted cause of death (Item 2	23a)	1				
drw 4	11/4	•	al Examiner 900 V			MD 21223			
St Regist	ate trar	31. Date filed (Month, Day, Year) UL 30 2012	32. Registrar's Signature	9. Span	Les .				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State State Registrar	ate of Marylar	-	artment o			lental Hy	20	112	25699
			Decedent's Name (First, Middle, Last)		06/	incate	- Death		2. Date of De	Reg. No. /	16	3. Time of Death
Physi Me	cian/ dica		ALICE	AFNIS					JULY Month	26 20	Year 12	11:55 A M
and the	nine	_	4a. Facility Name (if not institution, give street ar	nd number)		4b. City, Tow	n, or Location	on of Death		4c. County		
- A			3 ACKERMAN COURT  5. Social Security Number 6. Sex		44:31		EVENS				EN ANN	
Funer Direct		ľ	5. Social Security Number 6. Sex 1 $\square$ M 2	7. Age (In yrs. I	-	If Under 1 Y Months D	ays Hour	der 24 Hrs. rs Min.	8. Date of Bir (Month, Da		9. Birthp Count	lace (State or Foreign ry)
			Usual Residence of Decedent	98	Yrs.				10/19	/1913	MARY	'LAND
yland -f sho ed at	į		10a. State 10b. County		y, Town or Loc						1	0d. Inside City Limits
e Maı r 28a notifi	Director		MD QUEEN ANNE'S  10e. Street and Number	3	STEVENS		4.					1 🗆 Yes 2 🛣 No
vith th 23a o st be	2	<u> </u>	3 ACKERMAN COURT			10f. Zip Co	ue 1666			10g. Citizen of		-
15-0036 72 hours after death with the Maryland n'matural", or items 23a or 28a-f sho tedical Examiner must be notified at		runeral	11. Marital Status 12. Wa	s Decedent Ever in U.	S. 13. V			Origin? (Spec	cify Yes or No- Rican, etc.)	UNITE:	e - America	
36 fter d fter d	3	2	1 Never Married 2 Married 1	ned Forces? Yes 2 X No es, Give		Yes, specify (			Rican, etc.)	Dia	ck, White, e	tc.
OO. Durs a sufficient	Completed		3 LAWidowed 4 LI Divorced Yea	r or Dates.				ony:		Specify	WHI]	E
21215-0036 within 72 hours after giene. "natural", o is the Medical Exam	120	<u> </u>	15. Decedent's Education (Specify only highest grade comp		(Give k	ent's Usual Od ind of work do NOT use reti	ne during m	nost of workin	ng	16b. Kind of B	usiness/Ind	lustry
within giene.	[3		Elementary/Secondary (0-12) Coll	ege (1-4 or 5+)	1	MEMAKE	,			OWN	HOME	
land be filed ental Hyg rked oth	8		17. Father's Name (First, Middle, Last)				18. Mo	other's Name	(First, Middle,	Maiden Surnam		
Iryland 21215-0036  Juld be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	F	-	GEORGE POLITZ					HELEN	KOTSON	ES		
re, Maryla 1 and 2 should be if Health and Men item 27 is marke other traumatic.			19a. Informant's Name/Relationship (Type, Print	*)	1					r, City or Town, S	. ,	'
and 2 Healt tem 2		- 2	JAMES DAFNIS/SON 20a. Method of Disposition	20h F	1023 Place of Dispos			!	GRASON	/ILLE, M		ND 21638
mor age 1 ent of nt: If it			1 X Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	al from State	emetery, crem	atory or other	place)	AUGUS 2012	ST 1.		-	
Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important. If item 27 is marked oth any injury or other traumatic event any injury or other traumatic event	j.		21. Signature of Funeral Service Licensee	7								MARYLAND
a a a a a	5		1 5 + 1	<u></u>	- I	06 SHAI	ROCK	ROAD,	CHESTE	NAM FUN R, MARY	ERAL I LAND :	HOME, P.A. 21619
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the deat on each line.	h. Do not ente	r the mode of	dying, such	as cardiac or	respiratory and	rest,		Approximate Interval Between
Physicial Medic		- 1	Immediate Cause (Final disease or condition resulting in death)	CONCEST	JE H	SALT	FAIL	VILE			1	Onset and Death
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<b>68 / 60</b> certificate be noting physical use as the lead	Ž		F FEMALE: 23c. If ye	es, outcome of pregna	ncv						-11-	
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The Ticate			25. Was case referred to medical						1 Tyes		death?	2 □ No
/ITA sicial s certi	To Be		examiner?  1 Yes 2 No Hospital:	1  Inpatient 2	ED/O. A No A	T	Other:	eath (Check				
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DIVISION OT VITAI RECORDS, P.O. BOX 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriar-transit			29a. Certifier 1 Certifying Physician: To	the hest of my knowl	edge death a	courred of the	time data -	nd place as	d due to the	1100(0) 000	10r 00 -1 1	
ie Hos n 24 h e Fun sletely	Medical		(Check 2 Medical Examiner: On to only one) 3 Certifying Nurse Practi	he basis of examinatior	and/or investig	gation, in my o	pinion, death	occurred at t	he time, date a	nd place, and due	e to the caus	se(s) and manner stated.
To th withir To th comp	2		29b. Signature and title of certifier		,		ense numbe			29d. Date signed		
			Jame Mun	~		۵	4133	9		July :	27, 2	2012
-		3	30. Name and add ess of person who completed	cause of death (Item	23a) (Type, Pr	int)				2 ~	>	
	tate	3	JAMIS HUMMS MD 125	S H3/CWA 32. Registrar's Signat	Y URIV	E P	VENE N.	57361	MO	21658	5	
Regis			JUL 2 7 2012	Deneva	B. 14	bares						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alice Davis 0820 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NICOMICO PENINSULA Medien REGIONAL SALISBURY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Hours 234-78-4055 Director 1 □ M 2 🛛 F 71 7-25-1940 West Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits other treumetic event, the Made Examiner must be notified at Director 28a-f 1 Tes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23e 1707 Eastgate Drive, Apt. 300 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: "natural", White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiane. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I မ Mary Bud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paga 1 and 2 sh ment of Health an tant: If itam 27 Is 4623 Nassawango Church Road, Snow Hill, MD 21863 Ben Davis, Jr. - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of H Important: If its any Injury or ot once. 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Creamtory of Delmarva 7-28-2012 Delmar, Delaware Signature of Fundral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. P. nt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List ally one cause on each line. Immediate Cause (Final disease or condition resulting in death) SCVD Physician/ Medical Due to (or as a consequence of): Examiner Adenocorcinoma Metactatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the daeth certificata be executed within 24 hours after death.

To the Funeral Director: After this cartificata has baen signed by the attending physician end complately filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie D0066986 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MD 2/80/

Registrar DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #16a-b, 20b, per fh, g930 8-13-12 sm
State of Maryland / Department of Health and Mental Hygiene

For amend item 19b per fh g935 1-25-13 vt
Registrar

Reg. No. 20 | 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Year ELIZABETH ANN DELARODERIE JUL 05 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death WALTER REED NATIONAL MEDICAL CENTER **BETHESDA** MONTGOMERY Social Security Number 771-87-7007 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Y4 July 5 Year 2012 1 □ M 2 🕱 F Mary land Yrs. Director Usual Residence of Decedent show 10a. State 10b. County the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits rector 28a-f 1X Yes 2 No MD Anne Arundel Hanover ö 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral with t 23a 2641 Shade Branch Rd 21076 USA items ; and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 X Never Married 2 Married ģ Maryland 21215-0036 Specify: White Mexican 1 X Yes 2 □ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <del>-0</del> 0 0 Infant Infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Causey Delaroderie Karen Diane Goff 19b Maijing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John C. Delaroderie/Father Shade Branch Rd. Hanover, MD 21076 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Kremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 7/26/2012 Falls Church, VA permit. 21. Signature of Funeral Service licenses 22. Name and Address of Facility Murphy FH 4510 Wilson Blvd. Arl., VA 22203 CC0425 In Inniver 414 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death EXTREME PREMATURITY Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Uncertains Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicial. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2√ No 3 □ Probably 4 □ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page ; Yes 2 😾 No 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 💢 No မ 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 1 Natural Certificate: 28d. Describe how injury occurred injury 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practicus. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of bertifier 29c. License number 29d. Date signed (Month, Day, Year) Igil HIMD-11567 JUL 06 2012 completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MEDICAL CENTER KIMBERLY W. HICKEY, MD BETHESDA, MD 20889 32. Regiorrar's S State Registrar

State Registrar d. parks

O.C.M.E

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

August 2, 2012

30. Name and address of person who completed cause of death (Item 23a)

AUG - 6 201

Patricia Aronica-Pollak MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST MIRIAM C. ELBOURN 2012 12:30 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chester River Manor Chestertown Kent 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 214-32-1608 Director 1 □ M 2 🕱 F 78 May 14 1934 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Kent Rock Hall 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 5750 South Hawthorne Ave. 21661 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Black, White, etc. ☐ Yes 2 X No þ 1 Never Married 2 X Married "natural", or Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Kent County I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education Secretary and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Parker Coleman Sarah Myrtle Usilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. P. Jay Elbourn Husband 5750 South Hawthorne Ave., Rock Hall, MD 21661 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 8/8/12 Rock Hall, MD Wesley Chapel Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Galena Funeral Home of Stephen I, Schaech 118 West Cross St., Galena, MD 21635 21 Bignature of Funeral Service Licensee M01610 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between DEMEKTIA Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 menths? 1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ signed by the atter Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 this certificate has autonsy prior to completion of ause of death? Yes 25. Was case referred to edical director, 26. Place of Death (Check only one) Be examiner' Hospital Other 2 No 1 L Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completely filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only o 29b. Stanature and title of 29c. License number D0036054 Oppl no completed cause of death (Item 23a) (Type, Print) 190

DHMH 17 Rev 06-2011

State Registrar led (Month, Day, Year) AUG 1 3 2012 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For	State of M	laryland	d / Depa	irtment of I	Health and	Mental H	ygien	е		
			T = State Registrar			Cer	tificate of l	Death		Reg. N	.201	2 257(	) L
	Dhusisis	/	1. Decedent's Name (First, Middle	, Last)					2. Date of I			3. Time of Deatl	1
	Physicia Medi		Elvira Ver	onica Fo	oste				Month O7	2	ay Year	2:55 A	Μ
	Examir		4a. Facility Name (if not institution	, give street and number)				r Location of Dea	ith	4	c. County of Dea		
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	Funeral		5. Social Security Number		ge (In yrs. la:	st birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Birth Day, Year)	9. B	rthplace (State or Fore	ign
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	nd how at	=	10a. State 10b. County		10c. City	Town or Loc	ation		11/14	1192	+   Du.	10d. Inside City Lim	ite
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	with t	Funeral Director	5500 Friendshi	p Blvd.			20815			109.0	ILIZEIT OF WINAL C	UN	JK
	ems er mu	ij.	11. Marital Status	12. Was Decedent I		13. W	/as Decedent of H	lispanic Origin? (5	Specify Yes or No	0-	14. Race - Am		
9	or it	by	1 Never Married 2 Marr			If	Yes, specify Cuba	an, Mexican, Puer	rto Rican, etc.)		Black, Whi		
21215-0036	ırsafı ıral", IExa		3 X Widowed 4 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 ☐ No	Specify:	UN	JK	Specify:	UNK	
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<u>a</u>	shour and 7 is n		19a. Informant's Name/Relationsh	1 1 27 7	111		Address (Street						
o .	and 2		Clifton A. Fos	ter / Son			Drummone	d Avenue	Chevy	Chase	e, MD 20	0815 —————	
or	ge 1 a		20a. Method of Disposition  1  Burial 2  Cremation	3 Removal from State	20b. Pla	ace of Dispos metery, crem	ition (Name of atory or other plac	ce)	Date	20c. L	ocation - City o	Town, State	
ţi.	t. Pag tmen tant: jury		4 Donation 5 Other (S	pecify)	Nati		Cremator		6/2012	Fa.	lls Chui	ch, VA	
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service L	44			Name and Addres						
	TO = 0 0		William K,	Lugar MOO			30 Wisco				ngton, I	C 20016	
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that caused nly one cause on each line	d the death. e.	Do not enter	the mode of dyin	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between	
	Physi⊏in/		Immediate Cause (Final disease or condition	_ a Doncre	atic	Con	cer-1	retacto	tre to	liv	er	Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as	a conseque								
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52 -	g 70	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a	B Conseque	rine ct):							
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	re de / the ched	ysi	1 Yes 2 W No 9 Unknown	9 Unknown			Other (specify)						
VGの知にA Records, P.O.	hat the ed by deta	<u>Y</u>	Part II. Other significant conditio	ns contributing to death b	ut not resul	ting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?	
H)	lires t sign	g							1 🗆	Yes 2	□ No 3 □ F	robably 4 Unknow	wn
ord B	requ beer shou	Completed							24a. Wa	s an	24h Were al	topsy findings availab	le l
in Si	The law ate has page 2	Jmc							aut	opsy formed?	prior to	completion of cause o	f
> E	sician; The law roertificate has kilrector, page 2 s		25. Was case referred to medical				- 00 D		1 Tyes	2	o 1 □ Ye	s 2 No	-
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isi M	Atter r dea sctor by th	Certificate:	3 Suicide 6 Could r	not be 28e. Place of Inju	ıry - At hom	ne, farm, stree			28f. Location	(Street an	d Number or Ru	ral Route Number.	
Z Z	al or s afte Dire		4 - Hornicide determin	building, etc	c. (Specify)					wn, State			
- Ei	Spits hours mera ly fille	ica	29a. Certifier 1 Certifying	Physician: To the best of	my knowled	dge, death oc	curred at the time	e, date and place,	and due to the	cause(s) a	nd manner as s	ated.	_
RSIESL, ELIVISA Division of Vita	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral	Medical	Check 2 L Medical Ex	kaminer: On the basis of ex Nurse in actitioner: To the	xamination a	and/or investig	ation in my opinio	n death occurred	at the time date	and place	and due to the	causeo(s) and manner et-	ated.
15	Vith vith Con		29b. Signature and litle of certifier	1			29c. License				te signed (Mont		
	10		1 doubter	[ / \land \l			10	267		0	1/22/	2012	
	ı		30. Name and address of person w	ho completed cause of de	eath (Item 2	3a) (Type, Pri	nt)				1		
			Anitha Chetty M	D 8600 01d	Georg	getown	RD Beth	esda, MD	20814				
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	Physicia Medi		Robert				Fletcl	her				July 2	5, 20		Year	115	of Death M
	Examir	ner	4a. Facility Name (if		_	Veter	ane (	Str	4b. City, Town Charle				40	County St 1	of Death	Q	
	Funeral		5. Social Security N		6. Sex	7. Ag		ast birthday)	If Under 1 Yea	ar If U	Inder 24 Hrs.	8. Date of Bir			9. Birthr	place (Stat	e or Foreign
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36	after or I", or xamir	d by	1 ☐ Never Marr 3 🗓 Widowed		ried 1	l ♣ Yes 2 ☐ f Yes, Give	No		Yes 2x			rtiousi, cto.j			k, White, o		
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	d 2 shou ealth and n 27 is m er traum		19a. Informant's Na  Linda Mo						g Address (Stre 1 Lexin				,			,	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 X Burial 2 4 Donation	Cremation		oval from State	С	emetery, cren	sition (Name of natory or other p ns Ceme	<sub>/ace)</sub> tery	1	Date 1-2012			City or To		
Balti	permit. F Departm Importa any inju		21. Signature of Fu		icensee				Name and Add			Funera	1 H	ome (	Calve	rt, l	P.A.
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68	eath certificate be attending physic for use as the bu	M/u	IF FEMALE: 23b. Was decedent			f yes, outcome			ie.					23d. Dat	e of delive	ery	
Box	r the atte	Physician/Medic	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	4	Pregnant a			Ectopic pregna Other (specify)					Mo	nth	Day	Year
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Division of Vital Records,	sician: The law certificate has b irector, page 2 s	Completed by	Don	entin								auto	psy prmed?_	5	rior to cor leath?	mpletion o	f cause of
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ξ	hysica his ce Il direc	To	1 🗌 Yes 2 🖪		Hospi	1 🗌 Inpati		ER/Outpatien	t 3 🗆 DOA O	ther: 4 [	Nursing Ho	me 5 🗆 Resi	dence (	6 🗆 Othe	r (Specify)		
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Siol	Attendr deatl	rtific	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investig 6  Could determ	not be	Be. Place of Inj	ury - At ho	me, farm, stre	et, factory, office			28f. Location (\$	Street an	nd Numbe	r or Rural	Route Nur	mber,
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	' ,		30. Name and addre	ess of person v	vho comple	eted cause of c	leath (Item	23a) (Type, P		1	-		9	7		,	- /
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	Stat Registra		31. Date filed (Montl	JUL	30	32. Registr	s Signat		back	8							2062
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			For State	State of Mar		artment of F			2	012	25706
			Registrar  1. Decedent's Name (First, Middle, Last	)		runcate or L	Jean I	2. Date of Dea	Reg. No.	UIZ	3. Time of Death
	Physicia		Jane M.					Month July	Day	Year 2012	12:40 PM
	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Death	I JULY	4c. Cour	nty of Death	12.40 FM
			Elkton Care and	Rehab		E1kt	on			Cecil	
	Funeral		5. Social Security Number 6. Se 211-16-2850		n <i>yrs. last birthday)</i> 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day May 17	th y, Year)	9. Birthp Coun	lace (State or Foreign try) <b>Jersey</b>
	Director		Usual Residence of Decedent	ΑΛ	115.			May I/,	, 1924	New_	Jersey
	shov dat	tor	10a. State 10b. County	1	0c. City, Town or L	ocation				1	0d. Inside City Limits
	Mary 28a-f otifie	irec	Maryland Cecil		E1k	ton					1 🗌 Yes 2 🔼 No
	th the	al D	10e. Street and Number			10f. Zip Code			10g. Cîtizen d		
	ms 2 musi	Funeral Director	104 Woodholme Wa	y 12. Was Decedent Eve	rin 110 110		1921	neifu Van av Na	United		
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Z O	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Be (	17. Father's Name (First, Middle, Last)		ј поп	emaker	18. Mother's Nam	e (First, Middle,	Maiden Surna	Own Ho	ome
<u>la</u>	should be filed with h and Mental Hygien 7 is marked other the traumatic event, the	70	Alvin Henry Mill	er			Helen Ja				
Maryland 21215-0036	should and N is ma auma		19a. Informant's Name/Relationship (Ty)			ing Address (Street a					
	and 2 s Health tem 27		Janice Flood / Da	ughter		Woodholme	Way, Ell	cton, Ma	aryland	2192	21
saltimore,	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐	Removal from State		matory or other plac	e) Tulv	Date		n - City or To	
<u> </u>	iit. Pag irtmer irtant njury		4 ☐ Donation 5 ☐ Other (Specify 21. Signa e			e Cremato  2. Name and Addres	-			k, Del	
n n	permit. Page 1 Department of Important: If if any injury or o		21. Signal e	ee						-	yland21901
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or		e death. Do not en	ter the mode of dying	g, such as cardiac o	or respiratory arr	rest,		Approximate Interval Between
	Ph, sician/		Immediate Cause (Final disease or condition		tdvance	Dene	ntia				Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a c			(, (				
	<u> </u>	-e	Sequentially list conditions,	b. —							
)	ed sit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a co	onsequence oi):						
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2	e be e ysicia e buri	dical Examiner		d							
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٥ ×	th cert	Physician/Me	23b. Was decedent pregnant		Fetal death 3	Ectopic pregnanc	у			Date of delive	,
POX	e deat the at hed fo	ysic	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 ∐ Pregnant at tii 9 ☐ Unknown	me of death 5	Other (specify)			'	Month	Day Year
Ö.	ed by		Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use co	ontribute to th	e cause of death?
S,	ires the sign of t	d by						1 🗆 🕆	Yes 2 No	3 Prob	pably 4 Unknown
Vital Records,	v requ	Completed						24a. Was a		o. Were autop	sy findings available
ခိုင	he lay te has age 2	om						autop perfo 1  Yes	rmed? 2 <b>X</b> No	prior to cor death?  1  Yes	npletion of cause of
<u></u>	ian: T	Be C	25. Was case referred to medical examiner?			26. Pla	ace of Death (Check		2 2 110	1 🗀 163	2/25 110
5	hysic his ce	70	1 🗆 Yes 2 🔀 No		2 ER/Outpatie		er: 4 Nursing Ho	me_5 🗆 Resid	dence 6 🗆 O	ther (Specify)	1.6
וס ר	ling P	ate:	27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day, Y	(ear) 28b. Time of injury	work	?	28d. Describe h	ow injury occi	urred	
SIOI	death ctor: /	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home farm st		Yes 2 No	28f. Location (S	Street and Nun	pher or Pural	Poute Number
DIVISION	al or A s after I Director		4 ☐ Homicide determined	building, etc. (\$				City or Tow		iber or riara	rioute Nambol,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1. Certifying Phys (Check 2 Medical Examir	cian: To the best of my er: On the basis of exar	knowledge, death	occured at the time,	date and place, an	d due to the car	use(s) and ma	nner as state	d.
	the Ithin 24 the F	Me	only one) 3 Certifying Nurs	Practioner: To the bes		death occurred at the	time, date and place	e, and due to the	e cause(s) and	manner as sta	ated.
	<b>5</b> ≥ <b>6</b> 8		29b. Signature and title of certifier	My	MD	29c. License			29d. Date sign	ř	vay, Year)
			30. Name and address of person who or	ampleted cause of doct	h (Item 23a) (Time	Print) CIMIHA	062190	(HAN) M	D 2	3/12	
	4		30. Name and address of person who concern a series of person	INE HER	2 MAN H	NY, SUITE	A, CHE	SAPEAL	KECH	CY, M	D 21915
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	backer			-		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	FOI	partment of Health and N	/lental Hygie	ene	
				ertificate of Death	Reg	. No. 20 2	25/0/
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		2. Date of Death  Month  JULY	30 2012	3. Time of Death
	Medic	al	Allan L. Forsythe  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	July	4c. County of Death	11:35 A <sup>M</sup>
1	Examin	er	Johns Hopkins Bayview	Baltimore		None None	
	Funeral		5. Social Security Number 8. Sex 7. Age (In yrs. last birthday		8. Date of Birth	9. Birth	nplace (State or Foreign
	Director		407 62 8930 1 🕱 M 2 □ F 64 Yrs.	Workins Days Hours Willi.	(Month, Day, Ye 02/28/19		itucky
	nd how	ا ۾	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Aaryla 8a-f s tified	ect	MD Howard Columb	ia			1 🗆 Yes 2 🌁 No
	the N		10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Cou	intry?
	h with	Funeral Director	10209 Rutland Round Road	21044		United St	ates
	r deat		11. Marital Status  1 □ Never Married 2 ☑ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No	<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
036	be filed within 72 hours after death with the Maryland ential tyygiene. Wed other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show cevent, the Medical Examiner must be notified at	ed by	3 Widowed 4 Divorced If Yes, Give Year or Dates. 1968–72	1 ☐ Yes 2 🔀 No Specify:		Specify: Whi	.te
2-0	hour "natu dical	Completed	15. Decedent's Education 16a, Dec	cedent's Usual Occupation we kind of work done during most of work	ina 16	b. Kind of Business/I	ndustry
121	thin 72 than	mo	Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired)		37	
0 0	led wil Hygie other ent, th	Be (	12 Se:	nior Field Enginee	e (First, Middle, Maid	Xerox  den Surname)	
<u>a</u>	l be fill fental rked tic eve	၉	Harold Forsythe		Simpson	,	
ary	should be file n and Mental 7 is marked o raumatic eve	28	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	alling Address (Street and Number or Rura			
Σ.	0 ± 2 ±		4 4 .	09 Rutland Round Ro			
Baltimore, Maryland 21215-0036	0 <del>-</del> -		1 Rurial 2 V Cramation 3 Removal from State cemetery, co	rematory or other place)		c. Location - City or	
럂	permit. Page Department Important: I any injury o	10		on Cntr. of MD 7-32 22. Name and Address of FacilityHarr		anover, MI	
Ba	permit. Departn Importa any inju	1		4112 Old Columbia I			
П		П	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between
- F	Physician/		Immediate Cause (Final disease or condition Arrythmia				Onset and Death MINUTES
1	Medical Examiner		Due to (or as a consequence of):	luur - Mashauisal			months
	- 1/5	jer	Sequentially list conditions, if any, leading to immediate b. Bue to (or as a consequence of):	lure on Mechanical			months
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	ate be executed hysician and the burial-transit	E	resulting in death) Last Due to (or as a consequence of):	Line Delmaner Die			
9	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	d. Chronic Obstruc	tive Pulmonary Dise	ease		years
687	certific ding I	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	verv
XOX	eath c s atter d for u	icial	in the past 12 months?  1  Ves 2 No 4 Pregnant at time of death 5	B ☐ Ectopic pregnancy D ☐ Other (specify)		Month	Day Year
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<u>ч</u>	es that igned be de	by	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.		cco use contribute to	
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Ř	sician: The law in certificate has kilirector, page 2 s		25. Was case referred to medical	26. Place of Death (Chec	1 Yes 2	X No 1 ☐ Yes	2 No
Vita Vita	Physician: T r this certifica aral director, p	To Be	examiner? 1  Yes 2 No  Hospital: 1  Inpatient 2  ER/Outpat	Other:		e 6 Other (Speci	(v)
ot	ng Ph ter thi meral		27. Manner of Death 28a. Date of injury (Month, Day, Year)  28b. Time (Month, Day, Year)	of 28c. Injury at	28d. Describe how i	-	
on	tendir leath. tor: Af the fu	ifica	2 Accident Investigation	M 1 Tes 2 No			
NS	or At after c Direct	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
Ω	ospital hours neral y fillec	Medical	29a. Certifier 1X Certifying Physician: To the best of my knowledge, deal				
	the Ho nin 24 the Fu	Med	(Check 2 ☐ Medical Examiner: On the basis of examination and/or invonly one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowled				
	Voirt Con		29b. Signature and title of certifier	29c. License number		. Date signed (Month)	
7			w isp	D04383		July 30, 2	2012
		I I	30. Name and address of person who completed cause of death (Item 23a) (Type		1 ( 2	VD 21224	
5	5+		W. B. Greenough III MD 5565 Hopkins	Bayview Circle Ba	Itimore, I	MD 21224	
5	Star Registra		W. B. Greenough III MD 5565 Hopkins  31. Date filed (Month, Day, Year)  JUL 31 2012	Bayview Circle Ba	Itimore, I	MD 21224	

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fisher Irvin L. Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death DICOMIC 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Director 170-07-1584 1 🕅 M 2 🗆 F 93 Pennsylvania 02/03/1919 nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland authent of Health and Mertal Hyglene.
authent of Health and Mertal Hyglene.
Accident: If them 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be multiled at 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits Directo Maryland Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 9288 Hickory Mill Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 😿 No Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 🔀 No Specify: If Yes. Give Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Pilot Airlines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Irvin Y. Fisher Pearl D. Leiby permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is mark, any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Boyer/Personal Rep 933 Pine Heights Rd., Reading, PA 19605 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Salisbury Crematory 7/25/2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association Salisbury, 501 Snow Hill Rd., Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ RMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year detached 9 Unknown P.O. א Hospital or Attending Physician: וחפ ומוע ופקעוויסט אינה בייה ו-124 hours after death.

e Funeral Director: After this certificate has been signed by t steney filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 Na 1 Yes **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 2 ☐ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mapner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred A Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JUL 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State
Registra AMEND#18 per FH, 8/1/12; BMW, MoCo Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:07PM largaret 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washing Ton Social Security Number Adventisi Takoma Contgomer Park Hospita Birthplace State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In y Year If Under 24 Hrs. **Funeral** Hours 1 □ M 2 🖵 F **Director** 578-66-5166 62 9/3/1949 North Carolina Usual Residence of Decede 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Medical Examiner must be notified Prince Georges Capitol 1 XYes 2 No MD <u> Heights</u> ò 10e. Street and Numbe 10g. Citizen of What Country? items 23a Funeral United States 20743 <u>5270 Marlboro Pike Apt 204</u> Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ö Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates. Maryland 21215-0036 within 72 hours after Specify: Black 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dry Cleaning Presser 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <del>Oneda</del> 2 Onether Graham Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5270 Marlboro Pike #204 Capitol Heights, MD 19a. Informant's Name/Relationship (Type, Print) Allen Gray-husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State Department of Important: If any injury or once. 7/31/12 Beltsville, MD Chesapeake 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility  $W_{ullet}H_{ullet}$  Bacon Funeral Wanda C. Bacon 14th St., NW Washington, DC 20010 3447 CC0361 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Atheroscleratio Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed bural-trans and Due to (or as a consequence of) resulting in death) Last attending physician I for use as the burkal Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day Pregnant at time of death 1 Yes 2 Unknown been signed by the s should be detached a | Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 X No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury after death 1 Tes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one certifie 29d. Date signed (Month. Day. Year) 2012 Jul 00 6742 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ho, MD

State Registrar secrae

(Month, Day, Year)

7600

Carroll

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Greenfield Yvonne P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George Future Care Pineview Clinton Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country) 8. Date of Birth Hours Min. (Month, Day, Year) Director 218-74-9290 1 🗆 M 2 🕮 Maryland Usual Residence of Decedent 48 4-7-1964 should be filed within 72 hours and and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-f show a marked other than "natural", or items 25a or 28a-f show are covert, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Charles 1X Yes 2 ☐ No White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20695 USA 11105 Commanders Lane 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) vvas Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. 14. Race - American Indian Black, White, etc. 3 1 XNever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Domestic Retail traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ McPherson Francis D. Clara Greenfield and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 Commanders Ln, White Plains MD 20695 Betty Ann Davis- Sister other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St.Marys Cath. Ch 7-28-12 permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 🛭 Burial 2 🗆 Cremation 3 🗀 Removal from State Bryantown Maryland 4 ☐ Donation 🥱 ☐ Other (Specify) 21. Signature of Funeral Service Liou 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to r a a conseq Examiner Brain Sequentially list conditions, Examine dary, leading to immediate cause. Enter Underlying Due to for as a consequence of: anding physician and use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events APPROVED BY MEDICAL EXAMIN resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? vegetati 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 ☐ Yes 2 ☐ No ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical BB B 26. Place of Death (Check only one) examiner? Hospital: 2 🗌 No 욘 Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Funeral Director: After the etely filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending Accident
Suicide
Homicide 19/11/11 Investigation unknown 1 Tes deceased 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) unknown near hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funer

completely file 29a. Certifier (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day Year Name and address of person who completed cause of death (Item 23a) (Type, 3028 (0) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Donald Grace JüÏv 7:40A M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Nursing & Rehab Berlin Berlin 9. Birthplace (State or Foreign PA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F 2-15-1925 **Director** 87 172-20-6471 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland must be notified at Director 1 Yes 2X No MD Worcester Berlin 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral items 23a 10230 Harrison Road 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 21215-0036 1 ☐ Yes 2 XNo Specify: Spe Bylack Completed 3 X Widowed 4 Divorced Army Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Salisbury Steel Foreman Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ဂ Nellie I. Jordan Daniel M. Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 West 31st St, Wilmington, DE Daniel Grace, Jr/Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State <u>Cremation</u>, 7-21-2012 Dover, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility 917 W. Bennie Smith Funeral Home Salisby Isabella St. 21. Sign sure of Funeral Service Licenses Salisbury 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ply id n disease or condition 600 ear-/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentiany liet co. ditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated accords.) Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dedected for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 4 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 performed? death? this certificate 1 ☐ Yes 2 ☐ No Yes 2 director. 25. Was case referred to medica 26. Place of Death (Check only one) l a examiner? 2 4NO 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မူ 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After 5 Pending injury work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical

Registrar

29a. Certifier

only one 29b. Signature and title of cer

2 [ 3 [

William

26

31. Date filed (Month, Day, Year)

1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robins

9715

👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Healthway Drive.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Berlin

2181

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Man	/land / Depa	rtment of Healt	h and Menta	al Hygien

or Print in Black indelible ink. Ensure All Copies Are Legible.		1 00	
of Maryland / Department of Health and Mental Hygiene	20	12	25712
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Wieulcai Examin	ilei	Alphonse Wi.  4a. Facility Name (if not institu					- 1	4b. City, Town, or	Location of		July 19, 20	4c. Co	ounty of Dea	th	
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Funeral Director		5. Social Security Number 425-17-0455	6. Sex	K M 2 F	7. Age (I	n yrs. last 53	birthday) Yrs	Months Day	_	1.00	B. Date of Birt		Fore	irtnplace ign ountry)	AL
		Usual Residence of Decedent												Tand	nside City Limits
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e, N l and 2 Health item :		20a. Method of Disposition				20b. Pla		ition (Name of ce			Date /		ation - City o		
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Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Foureral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier (Check only one) 2 Medical E	Physicia	an: To the be	st of my ki	nowledge,	, death occu	rred at the time, d	late and plac	ce, and du	e to the caus	e(s) and n	nanner as sta	ated.	e(s)
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JM		30. Name and address of pers													
		Ana Rubio M.D., Ph		Assistant		Exami Signature		W. Baltimore	e Street,	Baltimo	ore, MD 21	223			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #15/16ab/19b perCertificate of Depart ELM 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ July 20 20<sup>Yga</sup>2 3:57 Рм Milton E. Hamilton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Country) unk Months Days Hours Min. 191-12-2003 1 🛣 M 2 🗆 F 88 Director 19, Sept. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Washington 1 Yes 2 X No Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 USA 5935 3rd Street NW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? unk 1 ☐ Yes 2 ☐ No Race - American Indian, Black, White, etc. Examiner 2 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 vithin 72 hours after nan "natural", c Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupati<del>on **Un**k</del> 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Alcholic Councler Government unk unkBe 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 1 and 2 should be file of Health and Mental Fitem 27 is marked o ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cons 19a. Informant's Name/Relationship (Type, Print) 5935 3rd street n.w. Washington, DC 20011 James Bennett / son or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State on National 8/12/12 Suitland MD 22. Name and Address of Facility State Anatomy Roard 4 ☐ Donation 5 🛛 Other (Specify) in state Washington National Licensee S, Wade, 21. Signature of Funeral S. rv Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) -transit and that initiated events resulting in death) Last Due to (or as a consequence of) use as the burialattending physiciar Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Pregnant at time of death g Unknown Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy Il or Attending Physician: The Is after death. Director: After this certificate h 2 No 1 Yes Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No ျှ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pendina 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifyling Nurse Practition at To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 000 60 100 -21-12 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA BMINA BLVD 31 Earl 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	or Maryland			of Deati			g. No. 20	12 2571	L	
	Physicia	in	1. Decedent's Name (First, Middle, Last)						Date of Death Month	Day Ye	3. Time of Death		
	/Medic	al	John Holland	tt 3		4b Otto Tro			uly	4c. County of D	<del></del>	_	
	Examin	er	4a. Facility Name (If not institution, give street and				n, or Location	n of Death					
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	Director		214-14-3376 <sup>¹∑™ 2□</sup>	F 9	3 Yrs.	Months D	ays Hours		ne 30	1919 M	aryland		
	pu ,		Usual Residence of Decedent	10- 6	Town or Loc	ation					10d. Inside City Limits	_	
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Baltimore, Maryland 21215-0036	0		1 XBurial 2 ☐ Cremation 3 ☐ Removal fr		ace of Disposemetery, crem					•	ille, Md.		
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	To t withi Com	Ž	29b. Signature and title of certifier	p' M.J.			29c. License number			29d. Date signed (Month, Day, Year)  Tirky 26, 2012			
	of p		30. Name and address of person who completed	Sective	23a) (Type, I	Print)	, Sui	te 204				5	

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201<sup>Yea</sup> Todd Andrews Haley 2:00 pM 17 July Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil 75 Chesapeake View Road Perryville 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 212-70-0403 Months Hours Min (Month, Day, Year) **Director** 1 📉 M 2 🗆 F 55 May 27, 1957 Delaware Usual Residence of Decede 28a-f show 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at Director 10d. Inside City Limits Cecil Perryville Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 21903 75 Chesapeake View Road U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married "natural", or þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify White Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 6b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) than ". Siemens Health Care of Elementary/Secondary (0-12) College (1-4 or 5+) Delaware Twelve Years Technical Support Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert B. Haley, Sr. Vivian Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 75 Chesapeake View Road, Perryville, Maryland 21903 Shelby N. Haley (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State West Chester, Date 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State 07/22/12 R.A.Ferris & Co., Inc. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21903**-**0766 Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one caus Immediate Cause (Final Onset and Death Physician/ enal disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and as the burial-transit 6 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (2014) nse 23b. Was decedent pregnant 23d. Date of delivery jo in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown funeral director, page 2 should be detached Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the use of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of Was an death? To Be 25. Was case referred to medical 26. Place of Deat eck only one) Hospital ☐ Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death.

I Director: Afted in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tit

Registrar

State

31. Date filed (Month, Day

TIVA

of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obeit	Michael	-	y Si 1-For State Registrar	ate of Maryla		artment o <i>rtificat</i> e o		Mental H		eg. No. 2 (	012 2571		
	Physici		Decedent's Name (First, Midd						Date of Deat     Month	Day Year	3. Time of Death		
nedica	al Exam	iner	1							012	0535 hrs		
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Rising Sun  4c. County of Dea Cecil										
	Funeral		5. Social Security Number	6. Sex 7	Age (In yrs.	last birthday)	If Under 1 Year Months Days		_		Birthplace (State or Foreign		
	Director		216-56-9288	Hours Min	04/08/		Country) VA						
	Any		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Locat	ion		<del></del>	<u> </u>	10d. Inside City Limits		
	<b>A</b>	_	MD Ce	cil	Ri	sing Su	n				1 Yes 2 X No		
	Aaryland 28a-f show 1 at once.	Director	10e. Street and Number				10f. Zip Code		10	0g. Citizen of Wha	t Country?		
	3a or 3		378 Weaver Mea	dows Road			21911			United S	States		
	eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Funeral	11. Marital Status 1 Never Married 2 X M	12. Was Dece Armed For			as Decedent of Hisp es, specify Cuban,			- 14. Race - White,	American Indian, Black, etc.		
	P 9 H			1 Yes	2X No	1	Yes 2 X No	specify:		Specify: V	White		
	ours aff	d by	15. Decedent's Education (Spe	or Dates:	completed)	16a. Deceder	nt's Usual Occupation	on (Give kind of		16b, Kind of Busi			
မှ	72 ho	lete	Elementary/Secondary (0-12)	College (1-4	4 or 5+)		ost of working life.	DO NOT use reti	ired)				
003	within giene. her th	Completed	12 17. Father's Name (First, Middle	Last		Supe	rvisor	9 Mother's Name	/First Middle A	Roller	Company		
21215-0036	e filed al Hyg ced oth	Be C	Unknown	, Last)				Nell (U	, , ,	naideir Surrame)			
21;	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine Department of Health and Mental Hygeine than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once	10 6	19a. Informant's Name/Relations	hip (Type, Print )		19b. Mailing	g Address (Street			ber, City or Town,	State, Zip Code)		
Δ	alth an		Lisa M. Hagy /	Wife	Look		eaver Mea		ad, Risi	ing Sun,	MD 21911 City or Town, State		
Baltimore,	es lan of He If ite ther tr		1 Burial 2 X Cremation	a 3 Removal from	m State	crematory or otl	her place)	7/2	4/2012		•		
Ë	it. Pag rtment rtant: y or o	- 23	4 Donation 5 Other S		R.	F. Foard	d Funeral	. Home,	P.A.	Rising	Sun, MD		
Ba	Depa Inju	12 J	France.	Mital		111	1 S. Quee	n St.	. Foard Rising S	Funeral Sun. MD 2	Home, P.A.		
	ysician		23a. Pan I. Enter the disease, or failure. List only one cause		used the death	n. Do not enter t	he mode of dying, s	such as cardiac o	or respiratory arre	est, shock, or hear	Approximate Interval Between Onset and		
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o,	s be ex /sician burial	ledical	UNPENDED	AMENDED						Tools			
876	eath certificate attending phy for use as the b	M/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, ou	utcome of preg th		tal death 3	Ectopic pregna	ancy	23d. Date of do Month	Day Year		
Box 6876	eath cer attendi for use	Physician/N		4 Pregna known 9 Unknow	nt at time of de	eath 5 Ot	her (Specify)						
B	t the de by the ached f	Ph	Part II. Other significant condit			resulting in the u	underlying cause gi	ven in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?		
Р.О	ires that signed I be deta	d by							1 Yes	2 No 3	Probably 4 Unknown		
rds	w requir s been s should	lete							24a. Was a		ere autopsy findings available or to completion of cause of		
ခွ	cian: The law certificate has ector, page 2 s	Completed							perfor 1 Yes 2	med? dea 2 ✓ No 1	ath? Yes 2 No		
<u> </u>	certific ector, p	Be C	25. Was case referred to medica examiner?	Heavital:		1		of Death (Check					
Column   C													
									or Rural Route Number, City				
ä	pital cours at reral D	4 Homicide determined (Specify) Residence 378 Weaver Meadows Road, Rising Sun, M									Rising Sun, MD		
	To the Hos within 24 h To the Fun completely		Check only	hysician: To the best miner:On the basis of									
	Tot with Tot com	Medical	29b. Signature and title of certifie	and manner sta			29c. License		· · · · · · · · · · · · · · · · · · ·		(Month, Day, Year)		
	10		anoto "				O.C.M	И.Е.		July 19, 201:	2		
			30. Name and address of person	who completed cause	of death (Item								
			Ana Rubio M.D., Ph. I	D. Assistant M	edical Exa	miner 900	W. Baltimore	Street, Baltir	more, MD 21	223			
	S	tate	31. Date filed (Month 1 y, Y2)	3 2012 32. R	istrar's Signati	ure /	excel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Frances M. Hackett 2012 25. 1:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 107 College Avenue Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Months Hours Min. (Month, Day, Year) Director 412-20-8832 92 1 🗆 M 2 🗶 F May 30, 1920 Tennessee or then "neture!", or iteme 23e or 28e-f ehow the Medical Examiner must be notified at 10a State 10b. County within 72 hours efter death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10.7 College Avenue 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, δ 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary U.S. Government Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed tment of Health and Mental Η tent: if item 27 le merked ot 18. Mother's Name (First, Middle, Maiden Surname) Rollie Mc Cov Lucy Spelling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Green /Daughter 307 Magnolia Ave./ Frederick, Maryland 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ÷ 5 1 Durial 2 Cremation 3 Removal from State permit. Page De artment o Importent: if any injury or 4 Donation 5 Other (Specify) Mount Olivet Cem. 07/27/2012 Frederick, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Family Services 1201 N.Market St./ Frederick, MD 23a. Part 1. Ease the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): After this certificate has been signed by the ettending physicien and funeral director, page 2 should be detached for use as the burlal-transit or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 2 No ျှ 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5XXResidence 6 ☐ Other (Specify) 24 hours after death.

Funerel Director: After this letely filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, the Hospitel Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of entifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥎 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 2010 Roberta Jones July 2012 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Harford Havre de Grace 8. Date of Birth (Month, Day, Year)
Sept. 2, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Months Days 1 □ M 2 🂢 F 214-20-8459 89 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Havre de Grace Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 567 Congress Avenue Funeral 21078 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 27 No
If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Completed by 3 ♥ Widowed 4 □ Divorced **Black** Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence Twelve Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Samuel Webster Susan Christie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Clark (Daughter) 567 Congress Avenue, Havre de Grace, MD 21078 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Chester R.A.Ferris & Co., Inc. 07/25/12 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 22. Name and Address of Facility 21. Signature of Funeral Service License Lee A. Patterson & Son Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, loading to mini ordinate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or sels consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 

Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 XNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1/2 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

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the attending physician death certificate be

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after death Director:

24 hours a

within 2

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Division of Vital Records,

the (

Hospital or Attending Physician: The law requires that

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**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprinter must be notified at once.

Maryland 21215-0036

Baltimore,

Examiner by Physician/Medical Completed Be Certification: To

28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier LU

27. Manner of Death

29a, Certifier

29c. License number DO063220

GEORGE

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

501 SCWW MYTON AVE, HAVR 31. Date filed (Month, Day, Year)

JUL 25

32. Registrar's Signature

and manner stated

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day June E. Jackson 5:20P 2012 Medical July 9 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berling Nursing & Rehab Center Worcester If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth **Funeral** Days Min. Hours 220-32-1396 1 M 2 TF reb 23, 1937 Director 75 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director MD Worcester Berlin 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10266 Harrison Road 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give 2 X No <u>\$</u>\$275-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Black 3 XWidowed 4 Divorced d 2 should he filed within 72 hours a alth and Mental Hygiene. 127 is marked other than "natural or traumatic event, the Medical Es Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Daycare Provider Davcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Walter Dale Grace Corbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) perr it. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Terry Smith/daughter 10266 Harrison Rd., Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Springhill 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7/27/2012 Hebron, MD <u>Memory Gárdens</u> 22. Name and Address of Facility Lewis N. Watson Funeral Home, 1618 West Road, Salisbury, MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2 HNo 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 🗌 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practimer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Robins, 1104 Healthway Drive, Berlin, 31. Date filed (Month, Day, Year) Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 20T2 12:52 PM Kathleen A. Jacobi Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 68 Edgewater Avenue North East Cecil Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 👿 F Months Davs Hours Min (Month, Day, Yea New York 80 222-16-3577 Director 193 Nov. 6, Usual Residence of Decedent 28a-f show 10b, County 10c, City, Town or Location 10d. Inside City Limits Director notified Maryland North East 1 Yes 2 KNo ō 10e Street and Number 10f Zin Code 10g. Citizen of What Country? ms 23a or must be r Funeral 68 Edgewater Avenue, Charlestown Manor 21901 United States 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No "natural", or ite Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: White Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1<sub>2</sub>4 or 5+) Elementary/Seconday (0-12) the Executive Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Daniel DelFeno Betty Malysh and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 i Anne Jacobi / Daughter 35521 Bonaire Drive, Rehoboth Beach, Delaware 19971 Baltimore, Important: If item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Julv<sup>Dat</sup>27. 1 Removal from State
4 Donation 5 Other (Specify) Cathedral Cemetery 2012 Wilmington, Delaware Signature of Edi 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland21901 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) oronary Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy Yes 2 No the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred I or Attending F after death, 1 Natural 2 Accident injury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical

10

<u>Jamil Khatri</u>

f certil

29a. Certifie (Check

only one 29b, Signature and tit

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4701 Olgetown Stanton RD Newark, DE. 19713

32. Registrar's Signature

🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 20 1°2 8:30 A M John E. Kelly, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bethesda 9300 Linden Ave. Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 092-12-6712 1 🛣 M 2 🗆 F Feb. 15, 1924 88 New York Usual Residence of Decedent r then "natural", or items 23e or 28e-f show the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Md. Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20814 9300 Linden Ave 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1944If Yes, Give 1067 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by Specify: White 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced 1947 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "na eny injury or other treumetic event, the Martal 20106. 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Special Agent Law Enforcement 4 F.B.I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Kelly Agnes Milet 19a. Informant's Name/Relationship (Type, Print) o Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11206 River View Drive Potomac, Maryland 20854 John M. Kelly/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Gate of Heaven 1 Burial 2 Cremation 3 Removal from State 28 4 Donation 5 Other (Specify) Cemetery Silver Spring, Md. Signature of Funeral Service bicense 22. Name and Address of Facility MO0215 DeVol Funeral Home 2222 Wisconsin Ave. N.W. Washington, D.C. 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Anorexia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events signed by the attending physician end resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signe; page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? After this certificate 2 X N 2 🗆 No 1 🗌 Yes Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ည 1 Tes 2 ₺ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | | 3 | | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 July 24, 2012 D26259 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 8218 Wisconsin Ave. #103, Bethesda, Md. 20814

M.D

Kaufman,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Medical Year Francine Keidel Dawn 18:45 pm 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REGIONAL MODICAL 544156414 TENINSULA Center HICOMICO Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8 Date of Birth Funeral (Month, Day, Year) Days 216-34-1314 Director 1 M 2 K F 74 12/18/1937 Utah Usual Residence of Deceden ir then "neturai", or items 23e or 28e-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Wicomico 1 Yes 2 xNo Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 4581 Nutters Cross Road 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Wildowed 4 Divorced Specify. Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) 10 Waitress Food Service permit. Page 1 and 2 should be filed w Department of Health and Mental Hygl Importent: if item 27 is marked othe eny injury or other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ethel Lee Abernathy Karl Synrex Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2219 Aaron Dr., Green Cove Springs, FL 32043 William L. Keidel Jr/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Riverton U.M. Church 4 Donation 5 Other (Specify) 7/27/2012 Mardela Springs, MD Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Immediate Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 4 Pregnant Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie OTE and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar
DHMH 17 Rev 06-2011

Wieland

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31. Date filed (Month, Day, Year)

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 20<u>12</u> Physician/ Month July Elmer T. Lasiter, Jr. 9:20 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Frederick Frederick Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 414-03-8710 1 ÅM 2 □ F Director 94 July 1, 1918 Tennessee Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Evarniner must be notified at 10a, State 10b County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 304 Sherman Ave. 21701 USA 11. Mantal Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 YYes If Yes, Giv Baltimore, Maryland 21215-0036 2 No WWII 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Chief Mechanist Government permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Elmer Lasiter Nell Casey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chanin Storm / Granddaughter 1719 Woodruff Way, Frederick, MD 21701 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery! 7/28/2012 Frederick, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a (Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Myocarden disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury) Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 💢 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 1 🗌 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 4309 7-24-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tou House Ave, Frederick, UD 2170/ 801 Laidi MO

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July Leffel 2012 8:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline House Mt. Airy Frederick 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days Hours Min. Director 219-46-8874 1 ፟ M 2 □ F 23,1954 Usual Residence of Decedent Maryland filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 K No Airy Maryland Frederick Mt. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12325 Sherwood Forest Drive 21771 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Shipping Department Clerk Heavy Equipment Dealer Be : If item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental F Important: If item 27 is marked o မ Emory Leffel Rubv Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary LaRocco / Cousin 12325 Sherwood Forest Drive Mt. Airy, Maryland 2177 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. Date 20c. Location - City or Town, State
West Friendship, 1 Burial 2 Cremation 3 Removal from State August Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) McKendree Cemetery Maryland 18, 2012 Signature of Funeral Service Licensee Stauffer Funeral Homes, P.A. Blvd. Mt. Airy, Maryland 21771 8 E. Ridgeville Blvd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. as the burial-transit within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physiclan and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဍ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month,

State Registrar

PK

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

32. Registrar's Signature

Year)

2

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland /				vientai riy	giene	0 05705
			Registrar  1. Decedent's Name (First, Middle,	( cot)		Cer	tificate of D	Death	T	Reg. No	2 20120
	Physicia	n/		ŕ		2. Date of Dea	26 Day 2012 e	ar 1:03 A <sup>M</sup>			
	Medic Examin	al									
	)		Calvert Memoria	l Hospital				Frederic	ĸ	Calve	
A	Funeral		5. Social Security Number		e (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h 9.	Birthplace (State or Foreign Country)
	Director		578-24-0610 Usual Residence of Decedent	1 □ M 2 💢 F	86	Yrs.			09-08-		hio
	and show	ō	10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits
	Maryla 28a-f	Director	MD Calver	`t		(	Chesapeak	e Beach			1 X Yes 2 No
	a or 2	io le	10e. Street and Number				10f. Zip Code			10g. Citizen of What	t Country?
	ed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at	Funeral	3519 Elizabeth			L.a.	2073			USA	
	r deat	y Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marrie</li></ul>	12. Was Decedent E Armed Forces? 1 \(\sum \) Yes 2 \(\sum \)			Vas Decedent of Hi f Yes, specify Cuba				American Indian, Vhite, etc.
920	s afteral", o	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	NO	1	☐ Yes 2 💢 No	Specify:		Specify:	White
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2	led within Hygiene, other tha ent, the l	Be	17. Father's Name (First, Middle, La	2	יע ן	ırec	tor, Pers			US Navy L Maiden Surname)	Department
anc	be file antal l ked o c eve	2	Charles Carter	siy .				Elsie		waluen sumame)	
ary	should be file and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship	p (Type, Print)	19	9b. Mailir	ng Address (Street a			r, City or Town, State	, Zip Code)
Š	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Bridgett Baumgar	tner, daugh	ter	1480	5 Ashford	Court,	Laurel,	MD 207 <u>07</u>	
ore			20a. Method of Disposition  1   Burial 2   Cremation	3 ☐ Removal from State			sition (Name of natory or other place	e)	Date	20c. Location - City	y or Town, State
Ē	. Page 1 tment of tant: If it tury or o		4 Donation 5 Other (Sp	pecify)	Wash:		on Nation			Suitland,	
Baltimore, Maryland	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lic		MO0715		. Name and Addres $325$ Mt. H			neral Home	e, P.A. 20736
			23a. Part 1. Enter the disease, or of shock, or heart failure. List on	complications that caused	the death. Do						Approximate Interval Between
wa.	Physician/	l S	Immediate Cause (Final disease or condition	Acute	4.1	cem	ija				Onset and Death
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X	ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 4 Pregnant a	2 Fetal dea		Ectopic pregnanc Other (specify)	у		23d. Date of Month	f delivery Day Year
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P.0	requires that the death certific been signed by the attending is should be detached for use as		Part II. Other significant condition	_			4			bacco use contribut	e to the cause of death?
ds,	quires en sig ould b	Completed by	Advanced Cerebro							/ -	Probably 4 Unknown
COL	aw rec as be-	ple	Acute Acidemia Diabetes mell T	/Acute Ren	d Fall	ure /	Acute 184	esp Instury Ar	24a. Was	an 24b. Were	autopsy findings available to completion of cause of
æ	sician; The law	Con		)-Insulin D	epender	-st /(	Chronic Hea	nt Fullurc	1 \( \text{Yes}	rmed? deat 2 No 1 □	Yes 2 No
ita	ysician is certifi director	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:			Othe	ace of Death (Chec			
Ž	Phys this ral di	မ	27. Manner of Death	1 Inpati	ent 2 ER/6	Outpatier  o. Time of	it 3 🗆 DOA	4 ☐ Nursing H		lence 6 Other (S ow injury occurred	pecify)
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vision c	r Attending F ter death. rector: After n by the funer		1 Natural 5 ☐ Pending	(Month, Day ation ot be 28e. Place of Inju	y, Year) iry - At home,		M 1 □	?			Rural Route Number,
Division of Vital Records, P.O. Box 687	oital or Attending Is us after death.  rral Director: After filled in by the funer	Certificate:	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could n 4 Homicide determin	(Month, Day ation of be ned 28e. Place of Inju- building, etc	ry - At home, c. (Specify)	farm, stre	M 1 □	? Yes 2 No	City or Tow	n, State)	
Division o	e Hospital or Attending I n 24 hours after death. e Funeral Director: After Netely filled in by the funer	Certificate:	1 Natural 2 Accident 3 Suicide 4 Homicide	(Month, Day ation of be lead 28e. Place of Injubuilding, etc.  Physician: To the best of laminer: On the basis of e	iry - At home, (Specify)  my knowledge xamination and	farm, street, death of	M 1 □  seet, factory, office  coccurred at the time tigation, in my opinio	? Yes 2 No  a, date and place, an, death occurred a	City or Tow	n, State) ause(s) and manner a	s stated. the cause(s) and manner stated.
Division c	To the Hospital or Attending Physician; The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as		1 Natural 2 Accident 3 Suicide 4 Homicide	(Month, Day ation of be a seed 28e. Place of Injubuilding, etc.)  Physician: To the best of aminer: On the basis of e Nurse Practitioner: To the	iny - At home, (Specify) my knowledge xamination and e best of my kr	farm, street, death of door investion	M 1 Description of the set, factory, office occurred at the time signation, in my opinion death occurred at the 29c. Licensee	Yes 2 □ No  e, date and place, a  in, death occurred a  he time, date and place  e number	City or Toward due to the cast the time, date a ace, and due to t	n, State) ause(s) and manner a	s stated. the cause(s) and manner stated. er as stated.
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Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical Certificate:	1 Natural 5 Pending Investige 6 Could n determin  29a. Certifier (Check 2 Medical Exonly one) 3 Certifying I	Month, Day ation of the led 28e. Place of Injubuliding, etc  Physician: To the best of laminer: On the basis of encountry  Physician: To the best of laminer: On the basis of encountry  Physician: To the best of laminer: On the basis of encountry  Physician: To the best of laminer: On the basis of encountry  Physician: To the best of laminer: On the basis of encountry  Physician: To the best of laminer: On the basis of encountry  Physician: To the best of laminer: On the basis of encountry  Physician: To the best of laminer: On the basis of encountry  Physician: To the best of laminer: On the basis of encountry  Physician: To the best of laminer: On the basis of encountry  Physician: To the best of laminer: On the basis of encountry  Physician: To the best of laminer: On the basis of encountry  Physician: To the best of laminer: On the basis of encountry  Physician: To the basis of encountry  P	iny - At home, (Specify)  my knowledge kamination and a best of my knowledge kamination and a best of my knowledge kamination and a best of my knowledge kamination and a best of my knowledge k	e, death c d/or invest nowledge a) (Type, F	M 1 □ set, factory, office  cocurred at the time tigation, in my opinio death occurred at the  29c. License  ①  Print)	? Yes 2 No  Adate and place, and, death occurred a the time, date and place	City or Toward due to the cast the time, date a ace, and due to t	un, State)  ause(s) and manner a nd place, and due to the cause(s) and mann 29d. Date signed (M	s stated. the cause(s) and manner stated. er as stated. onth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $J_{ulv}^{Month}$ <sup>Day</sup> 2012 Alice Ruth McGregor 26 1:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 50 Appeal Lane, Apt 202 Lusby Calvert If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖼 F Hours Min. 1072871933 Pennsylvania Director 578-86-9407 78 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits эегтіі. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 28a-f 1 ☐ Yes 2 🔀 No Maryland Calvert Lusby 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 20657 United States 50 Appeal Lane, Apt. items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc 9 1 Never Married 2 Married þ 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify: Specify: White If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natul other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Care Giver Child Care Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Elizabeth Widish Isaac N. Large, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Edwin McGregor / Spouse 50 Appeal Lane, Apt. 202, Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 07/31/2012 4 Donation 5 Other (Specify) MD Veterans Cemetery Cheltenham, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ANCER. disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate obuse. Enter Underlying Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After, this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events -tran Due to (or as a consequence of) resulting in death) Last -burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? ρ Day igned by the a be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 🗌 Yes Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 U Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No Natural 5 Pending iniury 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52242 July 26, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Barth, MD III 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

s Signature

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Physician/ Year MINION (D:42 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDA ANNAPOLIS ANNE UNDE MEDICAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral Director** 1 M 2 4 F 62 08/23/1949 Pennsylvania "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1104 Red Eye Road 20657 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White Completed Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pasquale Minnitte Wilma Poslusny .t. Page 1 and 2 shou...
•• of Health and Mr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard J. Minnitte / Son 110 Robin Lane, Hummelstown, PA 17036 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit, Page 1 Department of Important: If it any injury or o 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 07/28/2012 Alexandria, Virginia 22. Name and Address of Facility Rausch Funeral Home. P.A. Signature of Funeral Service Licens P.O. Nox 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a nonsequence of) cause. Enter Underlying Exami that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant at time of death 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s has autopsy certificate 1 Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ᅆ 1 Tes 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. eral Director: A filled in by the fi Accident М Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Daly, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LRW ANNAPOLIS, md 2000 PKNY TE 31. Date filed (Month, Day, 32. Registra State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #23b E&24b PerPHY G930 8/28/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ reorge 2012 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Hopkins Johns Hospi Social Security Number 6. Sex 7. Age (în yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 191-20-6333 1 M 2 □ F Hours **Director** 84 Pennsylvania 10/16/1927 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Edgewater Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **United States** Funeral 21037 3730 Bay Drive 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give 10/17-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced 1947-83 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Major General United States Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George L. McFadden, Sr. Frances Byrne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3730 Bay Drive, Edgewater, Maryland Floretta McFadden/Wife Date unk 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cemetery 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Arlington, Virginia 4 Donation 5 Other (Specify) of Funer 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signal 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardi Marction Phy i i n al disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Arteriosclerosis Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably W Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has I autopsy performed' XX No Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) Who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso 94 timor MD 21287 1800 Or leans 31. Date filed (Month, D State 2012 Registrar

TERRY L. McCLEARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25, per me, g932 10-22-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $J_{u}^{\text{Month}}v$ Physician/ 18<sup>Day</sup> 2019 Рм Terry L. McCleery 2229 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ceci1 9 Lovell Court E1kton If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Pennsylvania 1 🗓 M 2 🗆 F Months Days Hours Min. (Month Day 58 1954 Director 172-46-2068 January Usual Residence of Decedent init. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. In the 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No E1kton Maryland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Lovell Court 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced by 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 😾 No Specify Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Automobile Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Materials Team Leader Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ William D. McCleery, Sr. Jane Louise Ladner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 1314 East Connelly Boulevard, Sharon, PA 16146 William D. McCleery, Jr./brother 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Date Oakwood Cemetery Donation 5 Other (Specify) Sharon, PA 21. Signa re of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Day to for as a consequence of Exami -transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death the 9 Unknown s been signed by the should be detach Part II. **Other significant conditions** contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy has death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ျ 1 🗽 Yes -1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5  $\square$  Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 8 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jun H LOUISE 110 201 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner HOW ARD BENERAL COUNT DUILLESTA Hou If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 213 28 0738 1 🗆 M 2 🕱 F 12/27/1927 Maryland 84 iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits death with the Maryland Director 1 🗌 Yes 2 🔀 No Ellicott City MD Howard 10e. Street and Number 10g. Citizen of What Country? Funeral 21043 United States 8220 Maple Cliffe Way 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 and 2 should be filed within 72 hours after d if Health and Mental Hygiene. item 27 is marked other than "natural", or i other traumatic event, the Medical Examin 1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 XWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Motel/Restaurant Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frances Floyd Emmett Hardman . Page 1 and 2 should b ment of Health and Mei tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8220 Maple Cliffe Way Ellicott City, MD 21043 Brent D. Myers/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or other 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8-2-2012 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) St. Johns Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. (P 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Cerebro vas conar accident Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant a 9 Unknown 5 Other (specify) Pregnant at time of death g Unkn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 21-No 2 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 2 Accident work? 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: Of the pasis of examination a new miscongardon, many states and place and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 575 16 AZARIAN 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 30 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 2012 Physician/ Madelyn Elizabeth Miles July 23 9:13 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6838 Edwards Ave Salisbury Wicomico 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Director 1 🗆 M 2 🗶 F 05/01/1926 Delaware than "natural", or items 23a or 28a-f show ne Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 V No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6838 Edwards Ave. 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 X Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Clothing Manufacturing marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ Laurel Hanson Jones Lillie Belle Marvel injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie K. Adkins/Friend 6838 Edwards Ave., Salisbury, MD 21804 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 7/27/2012 Salisbury, MD 22 Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 ature of Funeral Service Licenses 3 avid 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVO Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ate has been signed by the atter page 2 should be detached for i in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 / No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2 No မ 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Hospital or Attending P 24 hours after death. Funeral Director: After t 28d. Describe how injury occurred Certificate: 1 🗹 Natural 5 Pending 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) F140131 PATROWICZ, 30. Name and address of pe JONATHAN 71C who completed cause of death (Item 23a) (Type, Print) Ste 31. Date filed (Month, Day, Year,

DHMH 17 Rev 06-2011

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clarence Nibblett 046 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbur <u>Peninsula</u> Regional Medical center Nicomico Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Davs (Month, Day, Year) Hours Min. 215-26-6774 Director 1 🛛 M 2 🗆 F 88 02/11/1924 Maryland Usual Residence of Decede permit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f show emy injury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Center Point Texas Kerr 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 78010 USA 400 Avenue B 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates in Force Black White etc. 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrician U.S. Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Martha Jane Parker Clarence James Nibblett Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 333, Center Point, TX 78010 William S. Nibblett/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Sam Houston 4 Donation 5 Other (Specify) 7/30/2012 San Antonio, TX Holloway Funeral Home Professiona 1.2.501 Snow Hill Rd. Salisbury, MD 21804 Naciona Sonature of Funeral Service Licensee \*Funeral Home Professional Association 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to for as a confusioned of it any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami To the Hospital or Attending Physicien: The lew requires that the deeth certificate be executed within £2 hours after death.

To the Funerel Director. After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physiclen: The lew requires that the deeth certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day ☐ Yes 2☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Dipatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 68552 NP 30. Name and add of person who completed cause of death (Item 23a) (Type, Print) 100 E CATION St. 31. Date filed (Month: Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ronnie Lee Powell 11:37 PM 2012 Ju<sub>1</sub>y 26. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1138 Muskogee Lane Lusby Calvert 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☑ M 2 □ F 63 04/09/1949 Director 218-50-4553 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f shov The Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20657 United States 1138 Muskogee Lane Funeral death and 2 should be filed within 72 hours after degent of Health and Mental Hyglene.

t: If item 27 Is marked other than "natural" or other traumatic event 12. Was Decedent Ever in U.S. Armed Forces?

1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1968–1972 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ※ No Completed by Specify Specify: White 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Mathematics School Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kathleen Lavenia Shiley Bruce Albertus Powell Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Buckner Powell / Wife 1138 Muskogee Lane, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ₭ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Gardens 08/01/2012 Great Mills, Maryland 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the despendence, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** ngestive disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events aftending physician and for use as the burial-tran resulting in death) Last P.O. Box 68760, Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy performed? 1 Yes 2 No this certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t al or Attending P To the Hospital or within 24 hours after death.

To the Funeral Director: At 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

(Check only one)

Signature and

use of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month. Dav. Year)

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For State Registrar			State of iv	iai yiai			te <i>of E</i>		and iv	nemai my	Reg. N	2	012	) 2	5734
Decedent's Name	e (First, Middl		mas Parr			2. Date of Death  South y 24 2012			1 Zear		me of Death				
	te Hal		reet and number) terans H			Location of Le Hal				c. Count Char	y of Death				
5. Social Security No. 218–12–02	last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Bi	rth axg/eat/	921		place (St Mano	ate or Foreign				
Usual Residence of 10a. State Maryland	10b. County			10c. Ci	ty, Town or Lo		d								de City Limits
10e. Street and Num 6310 S1		nard	Road			10f. Z	p Code 2068	35			_		What Cou		
11. Marital Status  1  Never Marri 3  Widowed		ried	2. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	Ever in U. No 42–44	ŧ.	f Yes, spe	cify Cuba	spanic Origi n, Mexican, Specify:	in? (Spe Puerto	ecify Yes or No- Rican, etc.)	United States  14. Race - American Indian, Black, White, etc. Specifywhite				
(Spe Elementary/Second 12	15. Decede cify only high onday (0-12)			5+)		kind of wo O NOT us	ork done d e retired)	uring most	of worki	ing	ng 16b. Kind of Business Industry Bus/Limo Servi				ce
17. Father's Name (F					1			18. Mother Made	r's Name elin	e (First, Middle e Bond	, Maiden	Surnam	ne)		
19a. Informant's Na Thomas F					19b. Mailir P.O.	g Addres Box	is (Street a	nd Number St.	r or Rura Leo	nard,	er, City a lary	and	St <b>206</b> 8	S <sup>de)</sup>	
20a. Method of Disp 1 A Burial 2 4 Donation	☐ Cremation		emoval from State		Place of Dispo cemetery, cren rist Ch	natory or	other place	9)	7/28	62012			- City or 1		<sub>te</sub> aryland
21. Signature of Fur	neral Service							s of Facility es Is		usch Fi . Port				D 20	676
shock, or hear Immediate Cause (I	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Approximate Interval Between Onset and Death  Due to (or as a consequence of):														
Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	nmediate rlying iinjury	c.	Due to (or as					-							
IF FEMALE: 23b. Was decedent in the past 12 r 1  Yes 2  9 Unknown	months?	23	c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 🗌 Fet	aldeath 3	Ectopic Other (s	pregnanc pecify)	/					ate of deli	very Day	Year
Part II. Other signifi	URE	10	Thri	vE			cause giv	en in Part I.							of death?
	TRU		VE UK	20F	PATH	4	·/~			24a. Was auto perf	psy ormed?_		prior to co death?	ompletion	ngs available n of cause of
25. Was case referre examiner?		L	- / OKI	7	1260	_40		ce of Death	n (Check	1 Yes	2 L N	lo	1  Yes	2 ∐ No	
1 🗌 Yes 2 🗓		Ho			ER/Outpatien			4 🗹 Nur	rsing Ho	me 5 Resi	idence (	6 🗆 Oth	ner (Specif	y)	
27. Manner of Death  1 Natural 2 Accident 3 Suicide	5 ☐ Pendii Investi 6 ☐ Could	gation	28a. Date of injury (Month, Day, Year) 28b. Time of injury			М	28c. Injury work	28d. Describe how injury occurred							
4  Homicide	determ		28e. Place of Inj building, et	c. (Specif	y)					28f. Location ( City or To	wn, State	e) 			lumber,
(Check 2	☐ Medical I	xamine	lan: To the best of r: On the basis of e Practioner: To the	examinatio	n and/or invest	igation, in	my opinio	n, death occ	curred at	the time, date	and place	e, and du	ue to the ca	ause(s) an	d manner stated.
29b. Signature and t	title of certifie	da	mel			29	c. License	number	i lu	D	29d. Da	ate signe	ed (Month,	Day, Yea	r) 12_
30. Name and address	ess of person		npleted cause of	death (Item	n 23a) (Type, P	Trint) R					ick	n	n a	206	78
31. Date filed (Month	- 40.00	25	32. Registr	s Signa	iture B.	ba	Med								

DHMH 17 Rev 7/2009

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 20°12 5:45 рм Mary E. Parker Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Caroline Envoy Health Center Denton . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Days Hours Min (Month, Day, Year Director 215-76-3589 1 M 2 X F 1935 Maryland 77 Yrs 1 May Usual Residence of Decedent than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits rector Maryland Anne Arundel Gambrills 1 X Yes 2 No 靣 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 271 Defense Highway 21054 USA death v 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Was Deceuen \_\_\_\_ Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc 1 Never Married 2 Married \$ Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black 3 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 6th Domestic Private Family Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked off any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Parker Benjamin Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3010 Hallmark Dr. Gambrills, Md. 21054 Katherine Henry (Guardian) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8/6/12 Baltimore, Md. 21. Signature of Funeral Service Licenses Wanname Reseases of Eacil Gons Mortuary, P.A. 21401 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) Examir attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Day is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ည 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Cify or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title o 27/2012

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of perso

31. Date filed (Month, Day, Year)

1. Book Prive Chity M 2/619

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

108

2-05452 Sail Ellen Phillips	3			Print in Black Indelible Ink. Ensure All Copies Are Legible.  Maryland / Department of Health and Mental Hygiene								10 0570
		1- For State Registrar	-	•	rtificate (				F	Reg. No.	20	16 6010
Physicia Medical Examir	ıer	1. Decedent's Name (First, Midd Gail Elle	n Phil	lips					Month July 20, 2	Day 2012	Year	3. Time of Death 1410 hrs
		4a. Facility Name (if not institution 80 Hickory Lane	on, give street and n	umber)		4b. City, Town	n, or Location	n of Death		4c. 0	County of Do	eath
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year If Un	nder 24Hrs.	8. Date of B	irth (MM/DI	D/YYYY) 9.	Birthplace (State or
Director		106-52-2606	1 M 2 X F		55 Y	rs. Months	Days Hou	urs Min.	09/20	)/195	6	country) New York
any	ŀ	Usual Residence of Decedent  10a. State 10b. County			, Town or Loc	ation						10d Inside City Limits
<b>≜</b>	5	MD Cec	il	E	lkton							1 Yes 2 X No
hours after death with the Maryland natural", or items 23a nr 28a-f shn Examiner must be notified at once.	Director	10e. Street and Number 80 Hickory La	ne			10f. Zip Co 2192				10g. Citize USA	en of What 0	Country?
ns 23a		11. Marital Status		cedent Ever in U		Vas Decedent of Yes, specify C				0- 1-	4. Race - Ar White, et	merican Indian, Black,
er death	Funeral	1 X Never Married 2 M 3 Widowed 4 Div	larried 1 Yes  /orced If Yes, Give Ye	2 X No	"	Yes $2X$			icari, etc.)	s		Black
ours afi atural'	ğ Ş	15. Decedent's Education (Spe	or Dates:			ent's Usual Occ most of working	upation (Giv	e kind of wo		16b. Kir	nd of Busine	ess/Industry
2 3 3	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)	_	memaker	y III.e. DO 140	or ago retire	u)	Own	n Home	9
21215-0036 buld be filed within 7 I Mental Hygiene, marked ather than ic event, the <u>Medica</u>	Be Con											
D sh and at	2											
ore, MC es l and 2 s of Health au If item 27	ŀ	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - Ci  Burial 2 X Cremation 3 Removal from State United Crematory 07/24/2012 Newark										
Baltimore, permit. Pages 1 an Department of He Important: If ite	l	4 Donation 5 Other S	pecify:	rom State U	Servi	ces			4/2012		ewark,	
Baltimo permit. Page Department or Important: injury or ntl	ſ	21. Signature of Funeral Service	Licersee		22	Name and Add Strano 635 Chu	tress of Faci & Feel	ley Fa	mily F	unera	al Hon	ne 702
Physician	1	23a. Part I. Enter the disease, of failure. List only one cause		caused the death								Approximate Interval Between Onset and
Examiner	Ì	Immediate Cause (Final disease or condition resulting in death)	a. Atheroscle	rotic Cardiov		isease						Death
		Sequentially list conditions,	b	a consequence (	), 							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		a consequence of	of):							
ecuted and transit	Exar	events resulting in death) Last	Due to (or as	a consequence of	of):							
8 5 5	dical	UNPENDED	AMENDED									
8760, ificate be exe ig physician	₩.	IF FEMALE: 23b. Was decedent pregnant in t		outcome of preg		Fetal death	3 Ecto	pic pregnan	су		Date of deli Nonth	ivery Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medic	past 12 months?  1 Yes 2 No 9 ✓ Un		nant at time of de	anth 🗔	Other (Specify)						
that the dined by the detached		Part II. Other significant condi			resulting in the	e underlying ca	use given in	Part I.				e to the cause of death?
ords, P. w requires th seen signer should be de	ed by	obesity							1 Ye			Probably 4 V Unknown e autopsy findings available
Cord law req has bee	Completed								auto	opsy ormed?		to completion of cause of h?
Vital Rec ysician: The his certificate director, page	S	25. Was case referred to medical	al			26.	Place of Dea	ith (Check o		2 ✔ No	1 _	Yes 2 No
Vita hysicia this cer	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie	ent 3 DOA	Other <sub>4</sub>		Home 5			ther: Scene
n of ding Pl h.	Ë	27. Manner of Death 1 ✓ Natural 5 Pen		e of Injury h, Day,Year)	28b. Time o	' '	Injury at Wo	_	8d. Describe	how injur	y occurred	
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the our after death.  eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deach	Certification:	2 Accident Inve	estigation 28e. Pla	ce of Injury - At h	nome, farm, st				28f. Location or Town,		d Number o	r Rural Route Number, City
E 5 5 5	al Cer	29a. Certifier 1 Certifying P	Physician: To the be	est of my knowled					lue to the cau	use(s) and		
To the How within 24 h To the Fur	edical	one) 2 Medical Exa	aminer: On the basis		and/or investi		inion, death		the time, date			to the cause(s)  (Month, Day, Year)
	Σ	29b. Signature and title of certifi	han ( N	D			Cense numb	-			21, 2012	
3		30. Name and/address of person Melissa Brassell, MD				W. Baltimo	re Street,	Baltimor	e, MD 212	223		
	_									_		

DHMH 17 Rev 1/2001 OCME 2006

Registrar

JUL 23 2012 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ralph Harry Pape 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-Regional Medical Center Cumberlana Allegany If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 218-24-8097 1 XM 2 | F 82 09-21-1929 Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location Funeral Director 10d. Inside City Limits MD Allegany Frostburg 1 Tyes 2 No 10e. Street and Numbe 10g. Citizen of What Country? 16717 Watkins Road U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1951
If Yes, Give 1053 Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 
Widowed 4 Divorced Specify: 1953 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cement and Supply 9 Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eleanor Niner Pape John Pape 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16717 Watkins Road Frostburg, MD 21532 Phyllis Pape wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 08-04-2012 Eckhart Cemetery Eckhart, MD 21. Signatu of Funeral Service License 22. Name and Address of Facility Sowers Funeral Home, P.A. 22 MO0541 60 W. Main Street Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph\_sician/ ulmorar Day Medical resulting in death) Due o (or as a consequence o **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events y physician and as the burial-tran resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy detached for in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant a
g ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 FR/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural iniury 5 Pending work?
1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I only one) 29b. Signature and title of certifie NIA 08,01.2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)
AUG 1 3 2012

12500

32. Registrar's Signature

Road

Willowbeccon

Cumperland MD-21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $J_{\mathbf{u}}^{Month}$ 2012 Robert Arden Reeves 3:28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert 510 Swaggers Point Road Solomons If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 1 M 2 □ F Davs Hours (Month, Day, Year) 08/24/1945 California 66 Director 560-68-0315 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Solomons Maryland Calvert 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral United States 20688 510 Swaggers Point Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Force Black White etc. Yes 2 3 No þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) US Government 5+ Program Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pearl Weston Arden Reeves ge 1 and 2 should it of Health and N If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Swaggers Point Road, Solomons, MD 20688 <u>Julia Ann Reeves / Wife</u> 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 07/30/2012 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Funeral Service Licensee P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANCR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to lor as a consuguence of cause. Enter Underlying Cause (Disease or linjury use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn 1 ☐ Yes 2 ☐ No 1 Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ျှ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier Escertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 = only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Da 33 HOSPITAL OR, #310 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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1000Y, MD

32. Registra Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 2012 Ruby Olabelle Johnson Reynolds 0815 July Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cecil 597 New Bridge Road Rising Sun Social Security Number 7. Age (In yrs. last birthday) 93 yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** North Carolina Aug. 6, <sup>Ye</sup>1918 218-05-1505 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland 10a State Director Examiner must be notified Rising Sun 1 Ves 2 X No Cecil Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò , or items 23a Funeral U.S.A. 21911 597 New Bridge Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any injury or other trainments. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Personal Residence Twelve Years Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Estella Hurley Walter Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Neal J. Reynolds (son) 631 New Bridge Rd., Rising Sun, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/27/12 Rising Sun, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Brookview Cemetery 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A.
Perryyille, Maryland 21903-0766 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final Athorosclerolie Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and -tran: Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No After this certificate within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 2 No 5 ■ Residence 6 □ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 은 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: iniury Natural 5  $\square$  Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 <u></u> (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7.23.2012

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

5

Election MD 21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | | | | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Riley July 22, 1;10  $p^{M}$ Robert L Medical 4a. Facilify Name (if not institution, give street and number, 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Wicomico Delmar Manor Assisted Living Delmar If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min 1 🗶 M 2 🗌 F 05/12/1927 Maryland Director 85 215-20-1092 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at Director 1 🗆 Yes 2 🙀 No Maryland Delmar Wicomico 10f. Zip Code ö 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be r Funeral 31093 E. Line Rd. 21875 USA items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Navy Examiner Black, White, etc. ō 1 Never Married 2 Married þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Completed 3 Divorced 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Manufacturing Company Rep Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Mae Jackson James Rilev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33135 Old Ocean City Rd., Parsonsburg, MD 21849 Hugh J. Riley/brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Jerusalem U.M. Church 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Depation 5 ☐ Other (Specify) 7/27/2012 metery | //2//2012 | Talebase | 1/2//2012 | T Parsonsburg, MD 23a. Part 1. Enter the disease, or complications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ac line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or impury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has certificate 1 Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Assisted 2 No ပ္ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this ( 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After iniury 1 Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director; A

Completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur 29c. License number 0 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) IVY FASTERN SHORF State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ANNA JOSEPHINE SIMMS 1740 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's 6001 Fisher Road, H205 Temple Hills Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Country) □ Δ **Funeral** Hours PA 77 02/28/1935 299-30-51,40 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Ħ 10d. Inside City Limits within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s idical Examiner must be notified 1X Yes 2 No Prince George's Temple Hills MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 AZU 6001 Fisher Road, H205 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black Specify: Completed 3 X Widowed 4 Divorced er than "natur , the Medical B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) al Hygiene. College (1-4 or 5+) I.R.S. Secretary permit. Page 1 and 2 should be filed win Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>tt</u> once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Mitchell Augustas Sales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 231 Prescott Avenue, Scranton, PA 18510 Darrell Yarbrough / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) hesapeake Crematory 01 2012 Beltsville, MD . Sign ture of Funeral Se 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gardeovasen Pnysician/ 205E disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 sate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner2 10 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner death filled in by the funeral Certificate: 28b. Time of 28c. Injury at atural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suic Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29h. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4005392 SIM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001

State Registrar

DHMH 17 Rev 7/2009

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arry Stansbury	, Jr.		ate of Maryland	/ Depa		of Hea	alth and			egible.	201	2 2574	
Physici	an/	Registrar  1. Decedent's Name (First, Middle	.Last)	Cer	uncate t	——	(U)	-	2. Date of De	Reg. No.	201	3. Time of Death	
Medical Exami									Month July 17,		rear .	0444 hrs	
		4a. Facility Name (if not institution				4b. City,	Town, or L	ocation of D	eath	4c. Coun			
		Upper Chesapeake Me	edical Center	_		Bel	Alr			Harfor			
Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. Ia	ast birthday)	If Un	der 1 Year ths Days	If Under 24 Hours	4Hrs. 8. Date of E	Birth (MM/DD/YY	YY) 9. Birti Foreigr	hplace (State or	
<ul> <li>Director</li> </ul>			1XM 2F	35	Υ	rs.	uis Days	Hours	09/1	7/1976	Cou	intry MARYLAND	
any		Usual Residence of Decedent  10a. State 10b. County		Inc. City	Town or Loc	ation						10d. Inside City Limits	
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Maryland 28a-f show	cto	10e. Street and Number	ARFORD		_		PRE DE	E GRAC	E	10g. Citizen of	Mhat Coun	21	
th the Maryland 23a or 28a-f sho notified at once	Director	626 FOUNTAIN	d Caberra			102	•	70		UNITED STATES			
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leath r item	Funeral	1 X Never Married 2 Ma	rried Armed Forces	X No					erto Rican, etc.)		hite, etc.	,	
after all", n	by F		rced If Yes, Give Year		1	Yes	2X No	specify:		Specif	y: BL	ACK	
5-0036 led within 72 hours dygiene. Infler than "natur the Medical Exami		15. Decedent's Education (Speci						on (Give kind	of work done	16b. Kind of	Business/Ir	ndustry	
6 4	plet	Elementary/Secondary (0-12)	College (1-4 or	5+)	-				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	İ			
21215-0036 uld be filed within 7 Mental Hygiene. marked nither than c event, the Medica	Completed	11 17. Father's Name (First, Middle, I	aet)		MUS	SIC P	PRODUC		ame (First, Middle			INMENT	
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D 212 should be and Menta 7 is marke	2	19a. Informant's Name/Relationsh	<u> </u>		19b. Maili	ng Addres			or Rural Route No	umber, City or To	own, State,	Zip Code)	
timore, MD 21215  t. Pages I and 2 should be file front of Health and Mental Hy reant: If item 27 is marked in y or other traumatic event, th		KATRICE STANSE	BURY / SISTE	ER.	419 1	MEADO	WOOD	DRIVE	, EDGEWOO	DD, MARY	ZLAND	21040	
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Baltimore, permit. Pages 1 a Department of He Impurtant: If ite	- 1	21. Signature of Funeral Service L				Name an	d Address o	of Facility			20111		
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Physician /Medical		23a. Fart I. Enter the disease, or of failure. List only one cause of		the death.	Do not enter	the mode	of dying, s	uch as cardi	ac or respiratory a	rrest, shock, or t	neart "	Approximate Interval Between Onset and	
Examiner		Immediate Cause (Final disease or condition resulting in death)	a Asthma									Death	
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	힐	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of	):								
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Box 68760, c death certificate be the attending physic ed for use as the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	ne of pregn		etal death	3 [				of delivery	ay Year	
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<b>∹</b> = ≥ 5	by P	Part II. Other significant condition	ons contributing to death	h but not re	sulting in the	underlyin	g cause giv	en in Part I.	23e. Did	_		ne cause of death?	
S, P.C									1 Ye	es 2 🗸 No	3 Proba	ably 4 Unknown	
cords aw requi	Be	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of											
tal Reco	Completed								perf 1 <b>✓</b> Yes	ormed? 2 No	death? 1 ✓ Yes	2 No	
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?							eck only one)				
Physical this	ē	1 ✓ Yes 2 No	Hospital: 1 Inpatie		ER/Outpatier					Residence 6			
Division of Vital Records, talor Attending Physician: The law requir is after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should	Ë	27. Manner of Death  1 Natural 5 Pendir	28a. Date of Inju (Month, Day,Y	iry 'ear)	28b. Time of	Injury	28c. Injury	at Work?	28d. Describe	how injury occu	urred		
ivisior or Attendate death Director:	cati	2 Accident Investi	igation 28e Place of In	iury - At ho	me farm stre	eet factor			28f Location	(Street and Num	aber or Purs	al Route Number, City	
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Divis  To the Bospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical		iner:On the basis of examination and manner stated.										
E 3 E 8	Me	29b. Signature and title of certifier	ana mainer stated.		11.	29	c. License	number		29d. Date sig	gned (Mont	h, Day, Year)	
		M		/ /	00		O.C.M	.E.		July 17, 2	2012		
	Ì	30. Name and address of person w		'	,								
		Russell Alexander MD.	Assistant Medic			W. Ba	Itimore S	street, Bai	ltimore, MD 2	1223			
St Regist		31. Date filed (Month ), Yes)	2012 32. Registra	r's Signatur		a Ka	,			OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 24 July 12:20 AM Hugo P. Silva Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Ceci1 36 Filbert Road If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Director 219-40-4436 1 🛛 M 2 🗆 F Yrs. 89 10/19/1922 Peru Usual Residence of Decede 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ms 23a or 28a-f shormust be notified at 10a. State with the Maryland Funeral Director 1 Yes 2 X No MD Ceci1 E1kton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 36 Filbert Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces ò þ 1 Never Married 2 X Married 2 X No Yes Baltimore, Maryland 21215-0036 Peruvian 1 X Yes 2 ☐ No Specify: If Yes, Give "natural", Completed 3 Widowed 4 Divorced Spanish Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Physician / OB GYN Medica1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rosa Renjifo Juan Silva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau <u> Carol Silva – wife</u> Filbert Road, Elkton, MD 36 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 7/28/2012 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Immaculate Conception Cemetery Elkton, MD ature of Funeral Service nsee 22. Name and Address of Facility R.T.Foard Funeral Home, PA E1kton, MD 21921 East Main Street, Part 1. Enter the disease, or complete shock, or heart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final ORONAVY Physician/ Medical resulting in death) Due to (or as a consequence of Examiner d Sequentially list conditions, harry, leading to in reduce cause. Enter Underlying Examine U To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-tra Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month þ Year Day 5 Other (specify) Pregnant at time of death 4 Pregnant
9 Unknown signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ No 3 Probably 4 Unknown Be Completed Hypertenion 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: ျှ 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) Manner of Death

Natural

Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No injury 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying flurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

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only one

Signature and title of certif

IMO

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Signature

29d. Date signed (Month, Day, Year)

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2012

19702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2<u>012</u> Physician/ <u>10:34</u>a™ Wallace W. Stickley Sr. July Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10521 Brenda Lane Ijamsville Frederick Social Security Number 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) Country) **Director** 219-34-9364 1 🖾 M 2 🗆 F Yrs 74 1938 | Washington D.C April 3, Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Frederick Ijamsville 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? Funeral 10521 Brenda Lane 21754 United <u>States</u> 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes. Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Operator Service Station 12 should be filed wif lith and Mental Hygie 27 is marked other r traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Vernon B. Stickley Evelyn Stanford 1 and 2 should be of Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janie E. Stickley/ Wife 10521 Brenda Lane, Ijamsville, Maryland 21754 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or oth Date 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Stauffer Crematory Inc. 7/30/2012 Frederick, Maryland. 21. Signature of Juneral Service (Li 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Home Prederick, Maryland 21702 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ending physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last igned by the attending physician be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) g Unknown signed by Part II. **Other signifi**cant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24 hours after death.

Funeral Director: After this certificate has been si etely filled in by the funeral director, page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perfor 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R10102 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rochelle Dyer Street Main 104 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State JUL 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 2<sup>Day</sup> 2012 7:00  $A^{M}$ Clarence Slayton, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick 4307 Millwood Road Mt. Airy Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 1 🖾 M 2 🗆 F 344-10-2505 99 March 8, 1913 Kansas Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4307 Millwood Road 21771 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 White f Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Mechanical Engineer Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence H. Slayton, Sr. Mary Elizabeth Larue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4307 Millwood Road Mt. Airy, Maryland 21771 Dolores M. Slayton / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State August 1, 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery 2012 Mt. Airy, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final uto 1 Cinur Physician Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 1 Yes 2 No ed by the a 9 Unknown signed by t Id be detach Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acitic 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been significate has been significated and functions are 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 AResidence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 24 hours after death.
Funeral Director: After this etely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06689 12 14150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Austin Pearre,

31. Date filed (Month, Day

M.D.

Frederick, Maryland 21701

300 W. Ninth Street

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Day 23 Month inda 0921 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL MEDICAL Center HIGOMICO TENINSYLA SALISDURY Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months Days Hours Min. Director 224-70-2926 1 🗆 M 2 🗓 F 63 2-18-1949 Virginia Usual Residence of Deceden "natural", or itams 23a or 28a-f shov edical Examiner must be notified at 10a. State 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene.
27 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Accomack Temperanceville 10e. Street and Number 10g. Citizen of What Country? Funeral 30121 Saxis Road 23442 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give ģ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Security Poultry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lynwood Collins Edith Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Haalth itam 27 l Garland Lee Taylor - Husband <u>30121 Saxis Road, Temperanceville, Virginia 23442</u> or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State parmit. Paga 1 s
Dapartment of H
Important: If its
any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Groton's Cemetery 7-27-2012 | Hallwood, Virginia Signature Fineral Service Licenses 22. Name and Address of Facility Thornton Funeral Home 24183 Chadbourne Street, Parksley, VA 23421 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiciani Cell Carcinona vamous disease or condition y cars Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Examine Due to (or as a consequence of): attanding physician and for use as tha burial-transit The law requires that the death cartificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day signed by the at id be detached for 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physician: Tha within 24 hours after death.

To tha Funeral Director: After this certificate I completaly filled in by the funeral director, pag Yes 2 K No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🕱 No 1 ☐ Inpatient 2 🕱 ER/Outpatient 3 ☐ DOA 잍 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signate d title of certifier 29c. License number M.D P30690 July 23 20/2

Registrar

DHMH 17 Rev 06-2011

State

Jones

31. Date filed (Month, Day, Year)

100

Corcoll St. Solisburg, MD 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	_ State	State of Maryland		rtment of H tificate of D			iene leg. No. 20	12	25747	
			1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Death 3. Time of Death							
	Physicia Medic	al .	MARY EMILY THOP					August				
,	Examin	er	4a. Facility Name (if not institution, give stre 32929 Cypress Rd.	eet and number)	4b. City, Town, or Millin			4c. County of Death  Kent				
	Funeral Director		5. Social Security Number 6. Sex 114-32-7073	7. Age (In yrs, Ia M 2 💆 F 89	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth April Day	5 <sup>xear)</sup> 1923	lace (State or Foreign fry) sylvania		
	how at	ž	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	ation				1	0d, Inside City Limits	
	// // // // // // // // // // // // //	Director	MD Kent	Mi	llingto	on					1 🗋 Yes 2 🔀 No	
	h the h ta or 2 be no	al Di	10e. Street and Number	-		10f. Zip Code			10g. Citizen of V	Vhat Coun	itry?	
	ath wit	Funeral	32929 Cypress Rd.	2. Was Decedent Ever in U.S	13. V	21651 Vas Decedent of His	spanic Origin? (Sp	ecify Yes or No-		e - Americ	an Indian,	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any righty or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Midowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates,	l I	Yes, specify Cubar	n, Mexican, Puerto	o Rican, etc.)		k, White, 6 Whit		
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212	within giene. ier tha		Elementary/Secondary (0-12)	se's Aid	e		Nursin	g Hon	ne			
Maryland 21215-0036	ould be filed nd Mental Hy marked oth matic event	To Be	17. Father's Name (First, Middle, Last) Hudson Cannon				18. Mother's Nar Sadie F		Maiden Surname)			
, Man	and 2 should Health and N tem 27 is ma other trauma	, X	19a. Informant's Name/Relationship (Type Lillie Alexander	Daughter		g Address (Street a		ral Route Number illingto				
Baltimore,	Page 1 an nent of He int: If iten iny or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Re 4 □ Dopation 5 □ Other (Specify)	emoval from State	emetery, cren	sition (Name of natory or other place emetery	e) 8/1	Date 0/12	20c. Location -	•		
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23a Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or beart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
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	Examiner		Sequentially list conditions, b.									
	sit of	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury									
	ate be executed hysician and the burial-transit	Exal	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):					-†		
09	te be e hysicia the bur	dical	d.							$\dashv$		
Box 687	death certifica ne attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	c. If yes, outcome of pregna 1  Live Birth 2  Feta 4  Pregnant at time of c	al death 3	Ectopic pregnand Other (specify)	sy			ite of deliv	ery Day Year	
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ital	ysician: The is certificate director, paç	Be	25. Was case referred to medical examiner?	ospital:	FD/0	Oth	ace of Death (Che	Home 5 Resid	James 6 17 Oth	ar (Cassif	A.	
Division of Vital Records,	iding Phys th. After this funeral d	cate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	28b. Time o injury	f 28c. Injur work	y at	T	ow injury occur			
ivisio	il or Attendi safter death. Director: A d in by the fu	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory, office		28f. Location (S City or Tov		er or Rura	l Route Number,	
	Hospita 4 hours Funeral tely fille	Medical	(Check 2 Medical Evamine	cian: To the best of my knower: On the basis of examination Practitioner: To the best of r	n and/or inves	tigation, in my opini	on, death occurred	at the time, date a	ind place, and du	ie to the ca	ause(s) and manner stated.	
	To the within 2 To the comple	2	29b. Signature and title of certifier	^		29c. Licens	e number		29d. Date signe			
	200		tredit I Va	- Nuren, so	5	1400 6	700		8-6	) - 1	1	
	) h		30. Name and address of person who cor Fredrick Van Dus				ena, MD.	21635				
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1 3 2012	32. Registrar's Signa								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 July 28, Physician/ Wilhelmina Vranken 1108 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Calvert-Burnett Hospice House Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) (Month, Day Ye **Funeral** Min 1 🗆 M 2 🛣 83 Netherlands Sept. Director 226-76-3429 1928 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 K No MD Calvert Huntingtown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral death with 1615 Maurham Court 20639 Netherlands 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White than "natural", 3 K Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Owner marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filer rtment of Health and Mental H rtant: If item 27 is marked of ပ Maria Dassen Laurens Dassen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 Maurham Court, Huntingtown, MD 20639 Mary Ann Hill (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 😾 Removal from State Mt. Comfort Cemetery Aug. 3, 2012 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lin 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lisa M. Mounts

23a. Part 1. Enter the disease, or complications that cause 8200 Jennifer Lane, Owings, MD 20736 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each me Interval Between Onset and Death Immediate Cause (Final Phylician/ disease or condition resulting in death) Medical Due to (or s a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause Ener Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last s been signed by the attending physician should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 94 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 € 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 🛪 No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother Spice House ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nuyse Plactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the only one) 29d. Date signed (Month, 29b. Signature and title 0

State Registrar 30. Name and address of

31. Date filed (Month, Day

eted cause of death (Item 23a) (Type, Print)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ VANCE  $5:30 \text{ A}^{M}$ LARRY TIIT 19 2012 Douglas Medical 4a. Facility Name (if not institution, give street and number) WALTER 4c. County of Death 4b. City. Town, or Location of Death Examiner MONTGOMERY BETHESDA REED NATIONAL MILITARY MEDICAL CENTE If Under 2 Year 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. 65 **Funeral** 1 🕅 M 2 🗆 F Days Min. Months (Month, Day, Year Country) 235-70-6910 Virginia Director 04/22 1947 West Usual Residence of Decedent 28a-f shov 10d. Inside City Limits if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2XXNo Waldorf MD Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20602 United States 3757 Primrose Dr. death 12. Was Decedent Ever in U.S. Armed Forces? YEYes 2 No If Yes, Give 1966 - 90 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Air Force Aircraft Maintenance Spe. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Wash Vance Wash ဂ Sybil Maynard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3757 Primrose Dr., Waldorf, MD 20602 Linda Sue Vance/Spouse 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ot cemetery, crematory or other place Arlington Nat. Ce: 10/31/12 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raymond Funeral Svc., 21. Signature of Funeral Service Licensee MD 20646 5635 Washington Ave., La Plata, 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition LUNG CANCER Approximate Interval Between Onset and Death Ph\_sician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death ed by the a detached 1 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) ours after death.

eral Director: After this certific filled in by the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 X Inpatient 2 - ER/Outpatient 3 - DOA 28d. Describe how injury occurred Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 X Natural 5 Pending work? 1 🗌 Yes 2 🗎 No Investigation Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined within 24 hours a

To the Funeral C

completed filled i Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

31. Date filed (Month, Day, Year, State AUG 1 3 2012 Registrar

29b. Signature and title of certifier

SEAN M. ROARK,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MILITARY MEDICAL

29c. License number

0101

247121

BETHESDA, MD 20889

29d. Date signed (Month, Day, Year)

CENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7/22 12 Ronette Eugenia Wilson 12:30 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery Olney Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Min. Hours 194 94 97 1 Director 577-80-7837 41 1 M 2 X F DC Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring MD 1 Yes 2 No ō 10e. Street and Number ral", or items 23a or Examiner must be r 10g. Citizen of What Country? United States Funeral 1500 Heather Hollow Circle #14 20904 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married Yes 2 X No Yes, Give Black, White, etc. þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Teacher's Aide 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Denise Webster Ronald Wilson Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 Crystal Wilson-daughter 1500 Heather Hollow Cir.#14 Silver Spring MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 7/30/12 Hyattsville, MD Harmony 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H. Bacon Funeral Home Wanda C. Bacon CC0361 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition NONCARDIUGENIC PULMONARY Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a nonsequence of): if any leading to immediat cause. Enter Underlying e attending physician and Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Pregnant at time of death 5 Other (specify) Day Year detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 ☑ Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work Investigation Accident М 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier ampl D0074376 07/22/2012 Ashok K. Sharma, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILIP DRIVE OLNEY MD PRINCE 20832

State Registrar Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death 250ay 20 Physician/ J Bert Wishart Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Glen If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Hours 028-18-4112 87 Director 1**X** M 2 □ F Aug. 12, 1924 Massachusetts permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Anne Arundel Gambrills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21054 2604 Chapel Lake Dr., #303 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No \$ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Completed 3 X Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Assemblyman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Gertrude Ackroyd John Bert Wishart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crofton, MD 1550 Crofton Parkway Celine G. Walsh / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Davidsonville, MD 8/1/2012 Lakemont Mem. Gards. 4 ☐ Donation 5 ☐ Other (Specify) Beall Funeral Home 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Bowie, MD 6512 NW Crain Hwy., Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the dis Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dire to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 X No ျှ 1 N Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Date signed (Month, Day, Year) 29b. Signat 2012

M State Registrar

Name and address of

31. Date filed (Month, Day, Year)

JUL 27 2012

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

1032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 24 2012 Physician/ РМ 3:00 enneth J Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Crofton 1304 Pleasant Meadow Road 9. Birthplace (State or Foreign 8 Date of Birth Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) **Funeral** Days Hours 019-24-5459 Director 1 M 2 - F 81 12/16/1930 Massachusetts 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 🏝 No notified Crofton Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 0 ms 23a or must be Funeral USA 21114 1304 Pleasant Meadow Rd. items death 14. Race - American Indian. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Year or Dates 1955-58 White Completed 3 Widowed 4 Divorced 16b. Kind of Business/Industry Board of Veterans 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Appeals Attorney Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Mendum 2 Walter J. Wells 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 1304 Pleasant Meadow Rd., Crofton, MD Pilar G. Wells / Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Sacred Heart Cemetery 7/28/2012 |Bowie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Rome 21. Signature of Funeral Service Licenses 6512 NW Crain Hwy. Bowie, MD 20715 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a contequence of) Examiner ongestive heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Coronary arten To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a coass quence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by renal insufficiency 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown history of rectal carcinoma 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy After this certificate has performed?
1 ☐ Yes 2 🗶 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certificate: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral to 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

N.

Registrar

29b. Signature

31. Date filed (Month, Day,

MD

JUL 27 2012

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2002 Medical

044161

Parkukuy #670, Amnopolis, MD 21401

29d. Date signed (Month, Day, Year)

26,2012

JUV

12-05512 Grant Wheeler		Please Type o	or Print in Bla of Maryland /							012 25	575
		I- For State Registrar		-	tificate of De		na monta	Re	g. No.		
Physicia Medical Examir		1. Decedent's Name (First, Middle,La Grant A. Whe	eler					2. Date of Death Month July 23, 20	Day Year	3 Time of Deat 1140 hrs	
		4a. Facility Name (if not institution, gi		-			or Location of D		4c. County of		
Funeral		9551 Fern Hollow Way  5. Social Security Number 6. S	ex 7. Age	(In yrs. la	,	aithersb		24Hrs. 8. Date of Birt	Montgom	9. Birthplace (State or	
Director		176 22 5040	M 2 F	83	-	lonths Da		Min. 12/28	,	Fore Pennsylv	
any		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Location					10d. Inside City	v Limits
nd sbow at		MD Montg	omery	. co. o.ty,	Montgome	ry Vi	llage			1 Yes 2	
Maryla	Director	10e. Street and Number 9551 Fern Hollo	w Way	_	10	. Zip Code	0.6	10	g. Citizen of Wha		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must he notified at once.		11. Marital Status	12. Was Decedent	Ever in U.	S. 13 Was De	208		? ( Specify Yes or No-	United	- American Indian, Black	ck.
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D 21. should bend Mer is mar	2	19a. Informant's Name/Relationship (				,		er or Rural Route Num		n, State, Zip Code) 21738	
e, MD and 2 sho Health and item 27 is traumati	ŀ	Laura A. Pettit			lace of Disposition	(Name of o		Date Date		City or Town, State	
Baltimore, permit. Pages I ai Department of He Important: If ite		Burial 2 X Cremation 3  4 Donation 5 Other Specify		te Me	rematory or other p tropolita	in Cre	em.	7/26/2012	Alexar	ndria, VA	
Saltil ermit. Separtm mports		21. Signature of Funeral Service Lice						Barber Fun			
Physician	$\dashv$	23a. Part I. Enter the disease, or com		Laytonsvil	le, MD est, shock, or hea	20882 rt Approximate I					
/Medical Examiner			ach line. Atherosclerotic (	Cardiov	ascular Diseas	e compl	icated by H	yperthermia		Between Ons Death	
		or condition resulting in death)	Due to (or as a conse	quence of	):						
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BO) he death y the att	Physician/Med	1 Yes 2 No 9 Unknow  Part II. Other significant conditions	9 Onknown	but not re			oivon in Part	23e Did to	hacco use contrib	oute to the cause of dea	ath?
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and burneral director, page 2 should be detached for use as the burial - transit	2	Tartii. Other significant conditions	continuating to death	Dathotre	saling in the ander	lying cause	s given arr air		2 <b>✓</b> No 3		known
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ftal sician: is certif irector,	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2	ER/Outpatient 3	26.Pla	Other		Residence 6	Other: Scene	
n of V ding Phy  After thi funeral d	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	J	28b. Time of Injury		ijury at Work?	28d. Describe h	low injury occurre		
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Divi	Certification:	3 Suicide 6 Could no determine	t be		ome, farm, street, fa nil <b>y Home</b>	ctory, onice	building, etc.	or Town, S		er or Rural Route Numbe nersburg, MD	er, City
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buril		29a. Certifier 1 Certifying Physic	ian: To the best of my								
To th withir To th comp	Medical	one) 2 Medical Examine  29b. Signature and title of certifier	and manner stated	nination a			nse number	rred at the time, date a		ed (Month, Day Year)	
		fants Rinther	11 mA			0.0	C.M.E.		July 24, 20		
15x1		30. Name and address of person who				D = 11.	ne Circ. i V	Dalkimana ARD a	1222		
	ate	Pameta E. Southall, MD 31. Date filed (Month, Ipa), Year)	Assistant Medi	's Signatu			ne street, t	Baltimore, MD 21	1223		
Regist		JUL Z I		and a	Te f. Jan	rice!					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Ronald Howard We		State of Maryla				Mental	Hygiene	<b>9</b>	010 0575
	1- For State Registrar 1. Decedent's Name (First, Mic	ddlo Laet)	Cer	tificate of	Death		2. Date of Dea	Reg. No.	3. Time of Death
Physician/ Medical Examiner							Month August 3	Day Yea	
	4a. Facility Name (if not institu	tion, give street and nu	mber)	4	b. City, Town, or	Location of De		4c. County of	
	Dorchester General		7. 4 // 10	as bidbida. Y	Cambridge	I WILL ALSO A	II. In Date of D	Dorches	
Funeral Director	5. Social Security Number	6. Sex	7. Age (In yrs. la	-	If Under 1 Year Months   Days		Min		9. Birthplace (State or Foreign
	219-70-8617 Usual Residence of Decedent	1 X M 2 F	47	Yrs.			Sept.	5,1964	Country) California
any	10a. State 10b. Coun	ty	10c. City,	Town or Location	on		-		10d. Inside City Limits
land f show	MD Tal	bot	East	on					1 X Yes 2 No
the Maryland a or 28a-f sh tiffed at once	10e, Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?
death with the Maryland or items 23a or 28a-f show must be notified at once.	714 Dover Road		edent Ever in U.	S I 13 Was	21601	nanic Origin?	( Specify Yes or N	USA 0- 14 Race	- American Indian, Black,
r death with or items 23 must be no Funeral	1 Never Married 2	A 1 F			s, specify Cuban			White	
s after d		Divorced If Yes, Give Year or Dates:	ır		Yes 2X No			Specify:	White
hours Exam	15. Decedent's Education (S Elementary/Secondary (0-1				's Usual Occupat est of working life.			16b. Kind of Bus	siness/Industry
5-0036 ed within 72 hour tygiene. otter than "natu the Medical Exar Completed	8	2) College (1	-4 01 5+)	Tree	Work			Arbor	ist
21215-0036 ould be filed within 72 hours after I Mental Hygiene. marked other than "natural", ic event, the Medical Examiner To Be Completed by I	17. Father's Name (First, Midd	le, Last)			T			Maioen Surname)	
121 d be fill ental H arked rwent, 1	Ronald H. We	•		1			a Ellen		
T atie is	19a. Informant's Name/Relation Vicky Lahman/						or Rural Route Nu n , MD 21	mber, City or Towr	n, State, Zip Code)
and the safe	20a. Method of Disposition			lace of Disposi	tion (Name of cer		Date	_	City or Town, State
MOFE Pages 1 a fent of He unt: If its	1 Burial 2 X Cremat 4 Donation 5 Other		UIII Glale	rematory or oth Shore	cremati	on 8/	/6/2012	Cambrid	lae. MD
Baltir permit. 1 Departm Importa	21. Signature of Funeral Servi	ce Licensee	-	22. N	ame and Address	of Facility			
	Poloute  23a. Part I. Enter the disease,	-,	ESP						dge, MD 21613
Physician /Medical	failure. List only one cau	se on each line.							Between Onset and
Examiner	Immediate Cause (Final disea or condition resulting in death		consequence of		IOI, alu M	CHECKIE	) and Alcone	ol Intoxica	LIOII
	Sequentially list conditions,	b.	consequence of	١.					
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	se c.							
vecuted n and - transit	events resulting in death) Las		consequence of	):					
© 1 m m 6	X UNPENDED		23a,27,	28a-f,p	er me,g9	30 8-29	9-12 sm		
OX 68760, each certificate be attending physic for use as the bur/sician/Mec	IF FEMALE: 23b. Was decedent pregnant in	the [	outcome of pregr	nancy	- [			23d. Date of	•
certification cian	past 12 months?	I L LIVE L	inth ant at time of dea	oth -	aldeath 3 [ er(Specify)	Ectopic pre	gnancy	Month	Day Year
Box 68760 e death certificate by the attending physi ed for use as the bu hysician/Me		Jnknown 9 Unkno			_				
ords, P.O. I we requires that the sabeen signed by the stand be detache pletted by PP PP	Part II. Other significant con-	ditions contributing to	death but not re	sulting in the u	nderlying cause g	iven in Part I.			oute to the cause of death?
ds, I							24a. Was	an 24b. V	Vere autopsy findings available
Records,  The law require finate has been signage 2 should b.		-						ormed? d	rior to completion of cause of eath?
tal Rection: The I certificate bector, page	25. Was case referred to medi	cal			26.Place	of Death (Che		2 No 1	Yes 2 No
i of Vital Recoing Physician: The law After this certificate has thereal director, page 2 sl 77. To Be Compl	examiner? 1 ✓ Yes 2 No	Hospital: 1	npatient 2	ER/Outpatient	3 DOA	Other <sub>4</sub> Nu	rsing Home 5	Residence 6	Other:
ing Ph After t funeral	27. Manner of Death  1 Natural 5 Death		of Injury , Day,Year)	28b. Time of Ir		y at Work?	28d. Describe	how injury occurre	ed
isior Attend or death ector: by the		vestigation	-3-12 e of Injury - At ho	fd 05:28	pm —	es 2 X No			r or Pural Poute Number City
Division of Vital Records, ospital or Attending Physician: The law require hours after death.  Interal Director: After this certificate has been siy filled in by the funeral director, page 2 should be Certification: To Be Completed		ould not be etermined (Specify)		:Reside		unung, etc.	or Town,	State) 5319 F	r or Rural Route Number, City Irst St.
S S S S S S S S S S S S S S S S S S S	29a. Certifier 1 CertifyIng	Physician: To the bes	st of my knowledg	ge, death occum	ed at the time, da		and due to the cau	se(s) and manner	
To the He within 24 To the For completed	29b. Signature and title of cert	and manner s			29c. License		ed at the time, date		ed (Month, Day, Year)
	anisto				O.C.1			August 4, 2	
	30. Name and address of pers	on who completed caus	se of death (Item	23a)				1	
	Ana Rubio M.D., Ph		Medical Exan		W. Baltimore	Street, Ba	ltimore, MD 2	1223	
State Registrar		Denew 32. Re	egi <b>st</b> rar's Signatu	te/car					

			For	State of M	arylan	d / Depa	artmen	t of H	lealth	and M	lental Hy	gien	е			
			1 - State Registrar			Cei	tificate	e of D	Death			Reg. N	0. 20	112	25	75
П	Physicia	in/	1. Decedent's Name (First, Middle, L								2. Date of De Month	D	ay	Year	3. Time o	f Death
	Medic Examin		Mabel Lilly Yir.  4a. Facility Name (if not institution, gi	<del></del>			4b City	Town or	Location	of Death	AUGUST	<u>5</u>	c. County	012	0713	5 AM
1	• Examin	ier		TAL OF B	ALTI	MORE	- "		NOR		LTY	4	c. County	of Death		
	Funeral		Social Security Number 6.	Sex 7. Age		ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir				lace (State o	or Foreign
	Director			1 □ M 2 🔀 F	92	Yrs.	Months	Days	Hours	Min.	(Month, Da 01/18			Coun M		
	nd Fow	ř	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation			1	01/10	77 17	20		0d. Inside C	ity I imits
	larylar Be-f s iffied	Director	MD Carrol	7		estmins										s 2 💢 No
	or 28		10e. Street and Number				10f. Zip	Code				10g. C	itizen of W	Vhat Cour		
	with s 23a ust b	Funeral	884 Eden Farm Ci	rcle				2115	57			U	SA			
	within 72 hours efter death with the Maryland glene. er then "neturel", or items 23a or 28e-f sho the Medical Examiner must be notified at		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S						cify Yes or No- Rican, etc.)			e - Americ k, White,		
36	efter I", or xami	d b	1 ☐ Never Married 2 ☐ Married 3 【XWidowed 4 ☐ Divorced	If Yes, Give	No		1 🗌 Yes				,			k, white, t		
21215-0036	nours eture cal E	Completed by	15. Decedent's	Year or Dates. Education		16a. Dece	dent's Usua	al Occupa	ation			16b	Kind of Bu			
215	n 72 t	Ę	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4 or 5	i+)	1 (Give	kind of woi O NOT use	rk done d		t of worki	ng	100.	Kiriu Oi Bu	1511 1625/11 11	rustry	
2	led within Hyglene. other the		12			homen	naker						own h	ome		
nd	e filed itel Hy ed oth event	To Be	17. Father's Name (First, Middle, Last	יי							e (First, Middle,	, Maider	Surname	)		
ž	should be file ond Mentel I is marked o reumatic eve		Harvey Hooper			η		l			Poole					
Maryland	12 shoullith end 27 is m		19a. Informant's Name/Relationship Brian Yingling/			19b. Mailii 884 E	ng Address Eden I	(Street a	and Numbe Circ	er or Rura le.	Route Numbe Westmin	er, City o	or Town, Si	tate, Zip (	ode) 157	
	E He		20a. Method of Disposition	·-·		Place of Dispo	sition (Nan	ne of			Date		Location -			
Ë			1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			emetery, crer	•		· .		7/2012	1		-		
Baltimore,	permit. Page Department of Importent: If eny injury or once,		21. Signature of Funeral Service Lice		TCAL				s of Factor	vitt:	s Funer	rall	<u>lipste</u> Home	and	Chanel	1
<u> </u>	Dep Imp		) M	1		4	112 Wa	shir	ngton	Roa	d, West	min	ster,	MD	2115	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused one cause on each line	d the deat	h. Do not ent	er the mod	e of dying	g, such as	cardiac d	r respiratory ar	rrest,			Approxima Interval Bel	
	Physician/	l (	Immediate Cause (Final disease or condition	. ACUTE	P	KESPII	RATO	RY	FAI	LUR	E				Onset and	Death
	Medical Examiner		resulting in death)	Due to (or as											-	-
		e.	Sequentially list conditions,	b. PULM Due to for se			EDE	EMA						-	3 DA	YS.
	ed nsit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Edo to for ac	a consequ	adilda dij.										
	execu n and ial-tra	Ä	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):								_		
09	or Attending Physician: The lew requires that the death certificate be executed after death.  Interdor: After this certificate has been signed by the ettending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	dical		d												
	tificat ng ph		IF FEMALE:									- 1				
Box 687	ettending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	2 Feta	aldeath 3			у			- 4		e of delive	*	
8	the e	ysic	1 ☐ Yes 2√2 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of o	death 5 L	Other (sp	ecify)					Mor	ntn	Day	Year
P.O.	thet the des ned by the e e detached	돈	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	underlying	cause giv	en in Part	l.	23e. Did t	obacco	use contri	ibute to th	e cause of o	death?
	requires the been signer should be a	Completed by Physician/M	LACTIC ACIDO	515.							1 🗆	Yes 2	No	3 Prot	ably 4 🗆	Unknown
ord	v requires	ig i	MON ST ELE	NOTTAN	200	CARDIA	th in	I PAI	RCTIC	N	24a. Was	an	24b. V	Vere autor	sy findings	available
Sec.	The lew ate has page 2	E										ormed?	P	rior to colleath?	npletion of o	cause of
a F	sician: The certificate rector, pag	Bec	25. Was case referred to medical examiner?	1				26. Pla	ace of Dea	th (Check	1 \( \text{Yes} \)	2121	No! 1	☐ Yes	2 Mo	
₹	Physic this ce	2	1 🗆 Yes 2 🖸 No	Hospital:	ent 2 🗆	ER/Outpatie	nt 3 🗆 D0	Othe	er: 4 🔲 Ni	ursing Ho	me 5 ☐ Resi	dence	6 ☐ Othe	r (Specify		
οl	ding P h. After ti funera	ate	27. Manner of Death  Natural 5  Pending	28a. Date of inju (Month, Day		28b. Time o injury	f 2	8c. Injury work	?	- 1	28d. Describe I	how inju	iry occurre	ed		
sior	Attending or death. ector: After by the fune	Certificate:	2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could not	he	AA b		M		Yes 2	No						
Division of Vital Records,	or Att after d Direct d in by		4 Homicide determine	28e. Place of Inju- building, etc	o. (Specify	me, tarm, str	eet, ractory	, опісе			28f. Location ( City or Tox			er or Rural	Route Numi	ber,
	To the Hospitel or A within 24 hours after To the Funerel Director Completely filled in b	Medical	29a. Certifier 1 Certifying Pl	nysician: To the best of	my know	ledge, death	occurred at	the time	e, date and	place, a	nd due to the c	ause(s)	and mann	er as state	ed.	
	in 24 in 24 in 24 in 24 in 24 in pletel	Med	(Check 2 ∟ Medical Exa	miner: On the basis of e urse Practitioner: To th	xamınatıoı	n and/or inves	tigation, in i	my opinio	in. death o	ccurred at	the time, date a	and plac	e and due	to the car	ise(s) and ma	anner stated
	Withi Com		29b. Signature and title of certifier				29c	. License	number			29d. D	ate signed	(Month, I	Day, Year)	
	1. ALAN		Nuther L	1BBS			R	ES.	- 00	0		AU	GUS	T 5	,201	12
	J 561		30. Name and address of person who	•				- 1 -		000		- ^				
	Sta	to	MACHIKET  31. Date filed (Month, Day, Year)	M. APT				NA	1 H	U>P	ITAL	01-	BA	LTIN	NORE	
	Sta Registra		AUG 1 3 2			1. Apa	Was									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2012 Physician/ Melvin Julius ZELTSER 3:10 P 4 August Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under: 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** (Month. Dav. Year Hours 101-32-8192 1 ★ M 2 □ F Director 71 Oct. 24, 1940 New York Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location at Director 1 🗆 Yes 2 🏲 No notified Silver Spring 28a-f Montgomery Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be n 20902 Funeral 1103 N. Belgrade Road United States items, death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. Completed by 1 Never Married 2 Married ☐ Yes 2 🗱 No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X☐ No Specify. 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Engineering Engineer 5+ 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ည Samuel Zeltser Anna Reisfeld 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 1103 N. Belgrade Road, Silver Spring, MD Helene Zeltser, wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, XBurial 2 ☐ Cremation 3 ☐ Removal from State Adelphi, MD Mt. Lebanon Cemetery | 08/05/12 4 Donation 5 27 one hinsky Hebrew Funeral Home 21. Signa um of Fu e a Se 20012 254 Carroll St., NW, Washington, DC 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary Arrest Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Massive Intracerebral Bleed With Herniation Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last the burialnding physician Completed by Physician/Medical Attending Physician: The law requires that the death certificate be PLPU ME JANNAE Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown g Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Hypertension 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 🗌 Yes 2 **X** No 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ျှ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural Accident 5 Pending within 24 hours after death.

To the Funeral Director. Aft
completely filled in Funeral 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Gom

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

Smitha Bhikkaji, M.D., 1500 Forest Glen Road, Silver Spring, MD

29c. License numbe

D 0064100

29d. Date signed (Month, Day, Year) August 4, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month C S Physician/ 2136 PM 0 ARPINO 2012 ARPINA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 12/18/1919 Hours 019-24-9294 92 1 🗆 M 2 💢 F Italy Director 10d Inside City Limits 10c. City, Town or Location 10a. State **Funeral Director** items 23a or 28a-1 somer must be notified 1 X Yes 2 □ No Arnold Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21012 605 Dunberry Drive permit, Page 1 and 2 should be filed within 72 hours after death with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. ıral", or item Examiner r 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: If Yes Give White "natural", Completed 3 XWidowed 4 ☐ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical. once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Eve Glasses Inspector Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Rosaria Mastrodemenico ပ Giacoma Palumbo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 206 Rock Street Norwood, MA 02062 Domenic Arpino 20b. Place of Disposition (Name of cemetery, crematory or other place)
Forest HillsCemetery 08/10/2012 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Boston, MA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee michael P 6009 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ OCan disease or condition resulting in death) Medical a consequence of **Examiner** Sequentially list conditions, I cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live Birth 2 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 No Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 🔀 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA မ 1 Yes 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certificate: injury 1 🔀 Natural 5 Pending Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ 29b. Signature and title of certifier al

State

31. Date filed (Month, Day,

Registrar

DHMH 17 Rev 06-2011

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Paskway Annapolis, MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 68 2012 1050 am Akinrinlola Julie 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Min (Month, Day, Year) 577-90-8096 1 □ M 2 □XF 61 Yrs 03-27-1951 Nigeria Usual Residence of Decede 10c. City, Town or Location 10d. Inside City Limits 10b. County Prince George's Riverdale 1 X Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 5907 61st Ave 20737 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status las Decede... rmed Forces? □ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Black 3 Widowed 4 X Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Executive Assistant Private 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Comfort A. Ogunfusika 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Olakanmi Akinrinlola/Son 18501 Fairlight Dr. #330 Gaithersburg, MD 20879 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 08-18-2012 Washington Nat Cem Suitland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Rd Hyattsville, MD 20785 23a. Part 1. Prier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate cause (Final Approximate Interval Between Onset and Death 3mall Bowel Obstruction Due to (or as a consequence of): Colon Cancer Metastic Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Year Day Month

Physician/ Medical Examiner

burial-transit

permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once.

Physician/

Medical

10a State

MD

Director

Funeral

by

Completed

Be

၉

Examiner

**Funeral** 

Director

28a-f shov

iral", or items 23a or 28a-f sho Examiner must be notified at

i 2 should be filed within 72 mouses alth and Mental Hygiene.

n 27 is marked other than "natural", or

other traumatic event,

Baltimore, Maryland 21215-0036

Examine attending physician for use as the buria Physician/Medical n signed by the a within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Christina Puchalski

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division of Vital Records, P.O. Box 68760

the Hospital or Attending Physician; The law requires that the hin 24 hours after death.

been

certificate has

funeral director,

disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No Pregnant at time of death Unknown 1 ☐ Yes 2 ■ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 IDOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

29c. License number

3001 Hospital Dr Cheverly, MD 20785

MD 30807 D.C.

29d. Date signed (Month, Day, Year)

08/09/2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registra 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2012 Month Physician/ 4: 50 PM O. LARENCE ARCORACE AUGUST **YUG** Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner MOWARD Columbia GENERAL HOSPITAL HOW ARD MUND 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth ocial Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Country) 216-24-4828 82 Yrs. Director 1 XM 2 □ F April 12 1930 MD Usual Residence of Decedent 10d. Inside City Limits an "natural", or items 23s or 28e-f show Medical Experient must be notified at 10b. County 10c. City, Town or Location death with the Maryland 10a. State Director Pasadena 1 Yes 2 X No Anne Arundel Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21122 8009 Fast Riverside Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black White etc. e filed within 72 hours after de tal Hygiene. ed other than "natural", or it ≥ 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 94 Union Local #16 Iron Worker 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith end Mental It 27 is marked o traumatic eve Carmela Torry ည Damenico Arcoraci. å end 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Church Hill, MD 21623 251 Carter Road item 27 Dean Arcoraci (son) 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 e
Department of H
Important: If ite
eny Injury or ot Aug. 012 cemetery crematory or other place)
Cedar Hill Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 13 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Liver 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, h line. Part 1. Enter the disease, or complicate shock, or heart failure. List only one can ediate Court / Financial Court / Fin Approximate Interval Between Onset and Death 23a. Part 1. Enter the dise Immediate Cause (Final ACCUPENT Physician/ disease or condition resulting in death) CEREBRANASCULAR Medical Due to (or as a consequence of): Examiner MSEASE END STAGE RENA Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin I or Attending Physicien: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funcated inector, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death q Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ ate has been signe page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2X No 1 Yes Yes 2 0 26. Place of Death (Check only one) 25. Was case referred to medical 8 examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Natient 2 ER/Outpatient 3 DOA 2 No မှ 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27 Manner of Death 28a. Date of injury Certificate: (Month, Day, iniury Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospitel of 24 hours a Medical 1 C-crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D50404 2012 08 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Little 21044 10632 Patrices Patel State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G930 8/16/2012 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 2 29P M Physician/ M5 8 200 Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death altimore M 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** curity Numbe 8. Date of Birth M 2 □ F Yrs. MD Director or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is anakried other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Limore 1 Yes 2 No mh 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Siona Be 17. Father's Name (First, Middle, Last) 18. Mgther's Name (First, Middle, Maiden Surname) 2 ee 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Numb Street MU21218 vonne 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 8/14/2012 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) tanover. 21. Signature of Funeral Service Licens Greene Functal Services Road /STOWN 23a. Part 1. Excer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or mart failure. List only one cause on each line. Approximate Interval Between Onset and Death et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and abe detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes page 2 should peen s Were autopsy findings available prior to completion of cause of death? 24a. Was an has within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 2 No 1 Yes the Hospital or Attending Physician; 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospita Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael Innes Annand 10'. 2012 August 1:26 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Hours 236-80-2384 Director 1 🗙 M 2 🗆 F 62 Yrs January 22, 1950 West Virginia or 28a-f show e notified at 10b. Count Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director Maryland Silver Spring Montgomery 1 🗌 Yes 2 💢 No 10e. Street and Numbe 10f. Zip Code ms 23a or must be r 10a, Citizen of What Country? Funeral 20910 1106 Edgevale Road United States ral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Yes 2 X No Black White etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0~12) College (1-4 or 5+) Program Manager Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked of traumatic ever မ Frank Annand Mary Ellen Myers 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 1106 Edgevale Road, Silver Spring, Maryland 20910 Annand / Wife Barbara 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot August 2012 ☐ Burial 2 X Cremation 3 ☐ Removal from State 13, cemetery, crematory or other place) Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funer Service Licensee M01305 Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, a heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Ventricular Fibrillation Medical resulting in death) Due to (or as a consequence of): Examiner 5 Days Acute Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of,... 5 Days or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Coronary Artery Disease Due to (or as a consequence of) P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law within 24 hours after death.

To the Funeral Director: After this certificate has: autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 \boxed{X} No ည 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Micheal 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

8110112

Annand

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yuri A. Deychak, MD 6410 Rockledge Drive, Ste. 200, Bethesda, Maryland 20817

a. Duchar

31. Date filed (Month, Day, Year) State AUG 1 4 201 Registrar

32. Registrar's Signature

D0041311

August 11, 2012

Please Type or Print in Black Indelibled by France Alb Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene AMEND ITEM#20b, Copies FH G930.8/24/2012, WS
Reg. No. 20 | 2 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death ARTHUR D. BEDELL Physician/ 201 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Regional Hospital Laure Laurel 5. Social Security Number 416. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) Director 71 Yrs 1 🕱 M 2 🗆 F LIBERIA 8/3/1940 or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD PRINCE GEORGE' LAUREL 1 Xes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o with 1 Funeral 9015 CONTEE RD #201 20705 LIBERIAN within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 X Married þ 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PILOT PRIVATE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WAH GREGORY BEDELL BEATRICE BEDELL permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 MULBURRY RIDGE CT PASADENA, MD.21122 THOMAS BEDELL/SON 9/5/12te 200. Browerwillle and Li 8/20/2012 Laurel, Maryland 9/1/2012 MONROVIA, LIBE 20c. Brewery illesat Liberia 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State TLLE CEM. 4 Donation 5 Other (Specify) CAPITOL MORTUARY 21. Sign dure of Funeral Service 22. Name and Address of Facility 1425 MARYLAND AVE NE WASH., 20002 or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failule. I Immediate Cause (Final Interval Between Onset and Death Myocardial Intarction Physician/ 1 hour disease or condition resulting in death) Medical Due to (or as a consequence of): W/4005392 Examiner 10 years Diabetes Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last as the burialphysician Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed d be de Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? Hypertension autopsy has page performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ည 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: eral Director: After filled in by the funer work? 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending an stany at December 25 Investigation 2000 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) tome # 200 within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 22966 Van Dusen Laurel, MD 7300 Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurei Regional Hospital Thomas H. Burguieres, MD 31. Date filed (Month, Day, Yea State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g930 8-30-12 vt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shirley Blowe Month Mae 20<sup>Year</sup>2 11:30PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2669 Edmondson Ave. N/A Baltimore 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 2/24/1934 9503 Days Hours Min Director 1 M 2 K 78 N.C. Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28e-f shov ent, the M-dic i Exertiner nust be nothed at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2669 Edmondson Ave. 21223 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9th N/A Baltimore City Cafateria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of treumetic ever permit. Page 1 and 2 should be file Department of Health and Mental I Importent: If item 27 is marked o eny injury or other treumetic eve once. Vest Royster Otelia Royster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dante Blowe-Son 2669 Edmondson Ave. Baltimore, MD 21223 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 8/13/2012 Baltimore, MD 21. Signature of Ture Service Licensee 22. Name and Address of Facility March F/H- East 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nostage disease or condition Medical resulting in death) te to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burlal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ VASUL 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 🗖 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi death. ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) walll 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 961 north CHAYles DON M-D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Las 2. Date of Death 3. Time of Death Physician/ Month 8 10AM Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3502 Kingsley Ct Apt E Pasadena Anne Arundel Social Security Number 6. Sex 8. Date of Birth (Month, Day, Yea April 28, 9. Birthplace (State or Foreign Country) Massachusetts If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday Funeral Days Hours Min. Director 034-18-6944 1 M 2 F 85  $^{'}1927$ Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3502 Kingsley Ct Apt E 21122 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Completed by Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) education teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Barron Robert Koppelman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 778 Willowby Run; Pasadena, MD 21122 Heidi Bonovich-Ashworth-daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Chroni disease or condition resulting in death) ear Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequential of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 🎦 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 (XNo Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 2 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) 0003658 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RCH 31. Date filed (Month, Day, Year) State Registrar

12-05721 Ezrakonay Bunch Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certin	ficate of	Death			Reg.	No	010	m
Physicia	ι'n/	Decedent's Name (First, Min	ddle,Last)					Manth	of Death	ay Year	U 11 lm	ime of Death / O
dical Exami	her	Ez-ra		onay		Bunch		Augu	st 1, 20	12		430 IIIS
## <u>*</u>		4a. Facility Name (if not institu	tion, give street and nu	imber)	4t	. City, Town, or Lo Baltimore	ocation of D	eatn		4c. County o	n Death	
7		Sinai Hospital  5. Social Security Number	6. Sex	7. Age (In yrs. last	hirthday)	If Under 1 Year	If Under 2	4Hrs. 8. Date	e of Birth(	MM/DD/YYYY	9. Birthpla	ce (State or
Funeral Director		215-08-4327		27	Yrs.	Months Days		Min. 03	30	85	Foreign Country	MD
As .	F	Usual Residence of Decedent 10a, State 10b, Coun		Inc. City. To	own or Locatio	n					10d	. Inside City Limits
ow any					ltimor						1 [	X Yes 2 No
Aaryland 28a-f show 1 at once.	흱	MD N	A	Da	LCIMOL	10f. Zip Code			10g.	Citizen of Wh	at Country?	
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ant of Health and Montal Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor other tranmatic event, the Medical Examiner must be notified at once.	Director	421 Fallswa	У			2120	2			U.S	S.A.	
with the same same same same same same same sam		11. Marital Status	12. Was Dec	cedent Ever in U.S.		Decedent of Hispa s, specify Cuban, N				14. Race White		Indian, Black,
death rriten	Funeral	1 X Never Married 2	1 Yes	2 X No				deno Mican, o	to. <i>j</i>			a le
after	by F		Divorced If Yes, Give Yes or Dates:			Yes 2 X No		d of work don	. 14	Specify: 6b. Kind of Bu	Bla	
hours after "natural", Examiner		15. Decedent's Education (S Elementary/Secondary (0-1		de completed) 1 1-4 or 5+)	during mo	s Usual Occupatio st of working life. D	OO NOT us	e retired)	*  '`	OD, KING OF BU	sii less/ii luus	nu y
36 in 72 han dical	Completed	12th grade	na conlege (	1-4 01 3+)	Dis	sabled				Disa	abled	
5-0036 lled within 7. Hygiene. I other than	튅	17. Father's Name (First, Mide	dle, Last)			18	3.Mother's N	Name (First, M	liddle, Mai	den Surname	)	
21215-0036 uld be filed within 72 Mental Hygiene. marked other than c event, the Medical	Be							erine				
2121 hould be fill and Mental I is marked utic event,	2	19a. Informant's Name/Relation			19b. Mailing	Address (Street	and Numbe	er or Rural Ro	ute Numbe	er, City or Tow	n, State, Zip	Code)
MD d shoulth and m 27 is aumati		Jermane Bost	on-Broth			ion (Name of ceme		way, C	JWIN:	Oc. Location -	City or Tow	Md 21117
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner		20a. Method of Disposition  1 X Burial 2 Crema	tion 3 Removal f	cre	ematory or other	er place)					-	
Page ment of		4 Donation 5 Other	Specify:	Gar				. 8/1.	3/20	12 Ow:	ings	Mills,MC
Baltimore, permit. Pages 1 an Department of Hee Important: If ite		21. Signature of Funeral Serv	ice Licensee		IMa.	me and Address of	Wes	t	. 7 2		Ma 2	1215
		23a. Part I. Enter the disease	or complications that	caused the death. D	0 not enter th	00 Waba e mode of dying, s	sh A	ve, Bo diac or respira	tory arrest	, shock, or he	art A	pproximate Interval
Physician /Medical		failure. List only one car	use on each line.	nd of Chest wit							l e	Between Onset and Death
Examiner		Immediate Cause (Final dise or condition resulting in death		a consequence of):		20113						
		Sequentially list conditions,	b									
# -	iner	if any, leading to immediate cause. Enter Underlying Cau		a consequence of):							_ 1	
Į.	Examiner	(Disease or injury that initiate events resulting in death) La		a consequence of):								
7 <b>60,</b> cate be executed physician and he burial - transi			d	H =		0/11/1001						
Sox 68760, death certificate be executed re attending physician and I for use as the burial - trans	Medical	UNPENDED		#1 Per M		8/14/201	LZ JH			23d. Date of	delivery	
		IF FEMALE: 23b. Was decedent pregnant		, outcome of pregna birth		al death 3	Ectopic p	regnancy		Month	Day	Year
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ords, P.O. Box 68' v requires that the death certificate been signed by the attending should be detached for use as 1	by P	Part II. Other significant co	nditions contributing	to death but not res	sulting in the u	nderlying cause gi	ven in Part					y 4 Unknown
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cords law requirence has been 2 should	Pet				<del></del>				autopsy perform	'   I	prior to comp death?	oletion of cause of
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f Vi Physi er this ral dira	မှ	1 Yes 2 No 27. Manner of Death	28a Dat	e of Injury	=R/Outpatient 28b. Time of Ir	<b>□ □ □</b>	y at Work?			w injury occur		
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Division tal or Attendiuns after death.  **A Director: A Director:	cat		nvestigation Jul 23, 28e. Pla	2012 ace of Injury - At hor	1620 hrs me, farm, stree	t, factory, office bu	uilding, etc				per or Rural I	Route Number, City
Divi pital or ours afte neral Div	ertif		Could not be determined (Specify	/ Local Street	t			5129 F	Town, Sta Reistersto	own Road, B	altimore, M	ID
Division of Vital   To the Hospital or Attending Physician: within 24 hours after deal: To the Funeral Director: After this certifi completely filled in by the funeral director,	၂ ပ	29a Certifier	g Physician: To the be Examiner: On the basis	est of my knowledge s of examination an	e, death occur d/or investigat	red at the time, dat	te and plac	e, and due to urred at the tin	the cause( ne, date ar	(s) and manne	r as stated due to the ca	ause(s)
To the within To the comp	Medical	29b. Signature and title of ce	and manner	stated.		29c, License				29d. Date sign		
	-	P 0 0	1/1000	0 1		O.C.N	И.E.			August 2,	2012	
(2)		30. Name and address of pe	rson who completed ca	use of death (Item 2	23a)							
		Carol H. Allan, MD	Assistant Med	ical Examiner	900 W. E	Baltimore Stre	et, Baltin	nore, MD 2	21223			
	tate		2012	Registrar's Signatur	back	les!						
Regis	1161	HAR T.	1 6915 Ala	mer la.	a -							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AND WI + Year Farline Baker 7:58 P M Medical 017 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Season's Hospice Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 03 24 31 Months Hours Min. 217-24-0843 Director 1 □ M 2 🖁 F NC 81 Yrs Usual Residence of Decedent I Hygiene. I chygiene "neturel", or items 23e or 28e-f show i other then "neturel", or items 23e or 28e-f show vent, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 U.S.A. 1739 Winding Brook Way 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married δ Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: 3 ₺ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Spring House Elementary/Secondary (0-12) College (1-4 or 5+) Assisted Living Nursing Assistant 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be filed nt of Health end Mental H I: If item 27 is merked ot ၉ Pauline White James Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1739 Winding Brook Way, Baltimore, Md 21244 Violetta Nixon--Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of h importent: if i eny injury or o ¹X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial \$/13/2012 4 ☐ Donation 5 ☐ Other (Specify) Arbutus, 21. Signature of Funeral Service Licenses Manager and Address of Weist 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ettending physicien end for use as the burlai-trensit deeth certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Pregnant at time of death signed by the evidence of significant sign To the Hospital or Attending Physicien: The lew requires that the within 24 hours efter death.

To the Funerel Director: After this certificate hes been signed by the completely filled in by the funerel director, page 2 should be detach. 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 2 🗌 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other:
4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) no paycameno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS Rejapa KSEMO 2535 SMIM AV

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

4 2012

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 25767

		1- For State Registrar		Certific	cate of	Death			R	eg. No.		
Physici		1. Decedent's Name (First, Middle		'I DI I				2	. Date of Dea Month	th Day Ye	ar	3. Time of Death
edical Exami	iner		Jonathan Dav	id Blanken	iship				July 31, 2		ai	1647 hrs
		4a. Facility Name (if not institution	n, give street and number	)	4	b. City, Town,	or Location o	f Death		4c. County	of Death	
		1402 N. Weldon Place				Baltimore						
Funeral			6. Sex 7. Ag	e (In yrs. last bi	irthday)	If Under 1 Ye	ear If Under	r 24Hrs.		th (MM/DD/YYY	7) 9. Birt	hplace (State or
Director		217-90-3582	1XM 2 F	40	Yrs.	Months Da	ys Hours	Min.	04/0	7/1972	Foreig	n Maryland
		Hard Baridan at Baradani	IM Z		Yrs.							
b b		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Locatio	n .						10d. Inside City Limits
iii		MD 165. Godiny		ioo. oky, row	II OI EOGGII		Baltin	noro				1 Yes 2 No
land f sh	ō						Daniii	11016				
Mary 28a-	Director	10e. Street and Number				10f. Zip Code	212		1	0g. Citizen of W		-
the differ		1402 N. Weldon Pla	ace				2121	1 1			U	SA
with with	Funeral	11. Marital Status	12. Was Decedent			Decedent of I				- 14. Race		can Indian, Black,
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her d		3 Widowed 4 Dive	orced If Yes, Give Year	<u> </u>	1	Yes 2 N	lo specify:			Specify:		White
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2 hor	ě	Elementary/Secondary (0-12)	College (1-4 or	5+)	during mo	st of working li			d)			
bin 7	Completed	12				Floori	ng Instal	ler			Servic	e/Retail
ther giren	ő	17. Father's Name (First, Middle,	Last)				18.Mother's	s Name (f	irst, Middle, I	Maiden Surname	9)	
State of the state	Be		Danny Blanken	ship					I	Diana Keffe	er	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	0	19a, Informant's Name/Relationsh	nip (Type, Print )	119	9b. Mailing	Address (Str	eet and Num	ber or Ru	ral Route Nun	nber, City or Tov	n, State,	Zip Code)
MOVE, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ant of Health and Mental Hygiene.  ant: Offen 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once.	_	Krista Blankenship		1:	2910 Pi	ne Street,	Ocean C	City, M	D 21842			
nnd 2 alth 2 em 2		20a. Method of Disposition		20b. Place	of Disposit	ion (Name of o	emetery.		Date	20c. Location	- City or	Town, State
of He		1 Burial 2 Cremation	3 Removal from St	ate crema	atory or oth	er place)					. 14 1	II- MD
Page Page nent ant:		4 Donation 5 Other Sp	ecify:	Cne	esapeak	e Cremato	ory	8/11	/2012	E	eitsvi	lle, MD
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Martlal Hygiene. Important: If item 27 is marked other than "natural", or items 13s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service		1 1		ame and Addre				D 1440	n 1.1	145 04000
O 2545		Dorota Marshall	Jacobs 4. ll	outhout	[ ]	Maryland	Crematio	on Serv	vices, PO	Box 1413.	Baltın	nore, MD 21203
Physician		23a. Part I. Enter the disease, or failure. List only one cause		I the death. Do r	not enter the	e mode of dyin	g, such as ca	ardiac or r	espiratory arr	est, shock, or he	art	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease	a. Gunshot Wound	ds (2) of He	ad and C	Chest						Death
Examiner		or condition resulting in death)	Due to (or as a cons									
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Box 68°.  he death certifi  the attending  hed for use as a	Physician	1 Yes 2 No 9 Unk	nown 9 Unknown		O[]	el (opecity)						
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J of Jing Ph After t funeral	ä	27. Manner of Death	28a. Date of Inju		. Time of In	jury 28c. In	jury at Work?			how injury occur t by police	red	
On cending or: /	엹	1 Natural 5 Pend		163	37 hrs	1	Yes 2	No S	ubject silo	t by police		1
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Hosp 4 hou Fune ely fi		00- 0-45	ysician: To the best of m	y knowledge, de	eath occurr	ed at the time.	date and pla	ce, and d	ue to the caus	se(s) and manne	r as state	ed
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To To con	Mec	29b. Signature and title of certifie	and manner stated.		•	29c. Lice	nse number			29d. Date sign	ed (Mor	nth, Day, Year)
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Mili		Mentio	usself "	2						]		
HU		30. Name and address of person	who completed cause of o Assistant Medica			Raltimore	Street P-	altimora	MD 2422	23		
V		Melissa Brassell, MD				Daitimore	Street, Ba	ailiiiiOfE	;, IVIL) Z 1 Z 2			
St Pogis	tate	31. Date filed (Month, Day Year)	32. Registra	ar's Signature								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Christine N Benton	1- For State	ate of Marylan		ment of icate of i		Mental H		eg. No.	201	2 2578
Physician/				-			2. Date of Dea	th Day	Year	3. Time of Death
Medical Examine				- Ta	Oit. Town and		August 5,	2012		1430 hrs
7	4a. Facility Name (if not institution Sinai Hospital	n, give street and numb	er)	40	. City, Town, or L Baltimore	ocation of Deati	n	4c. Coul	nty of Death N/A	
Funeral	5. Social Security Number	6. Sex 7.	Age (In yrs. last t	birthday)	If Under 1 Year	If Under 24Hrs	s. 8. Date of Bir	th(MM/DD/Y	YYY) 9. Bir	thplace (State or
Director	079-60-9325	1 M 2 XF	36	Yrs.	Months Days	Hours Mir	03/2	5/197	6 Foreig	gn puntry) NY
	Usual Residence of Decedent									
w any	10a. State 10b. County	/.	10c. City, Tov							10d, Inside City Limits 1 Ves 2 No
yland -f sho	MD  10e. Street and Number	N/A			imore		[4	0g. Citizen of	F Mbat Cou	
vith the Maryland 23a or 28a-f show a cotified at once. al Director	4310 Penhurs	+ A				215				my:
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death with nr items 2: must be no Funeral	1 Never Married 2 M	arried Armed Force	es?	If Yes	s, specify Cuban,	Mexican, Puerto	Rican, etc.)	W	Vhite, etc.	
safter de rall', un inter m	3 Widowed 4 Div	orced If Yes, Give Year or Dates:		]	es 2X No				ity: Bl	
hours Latur		cify only highest grade of College (1-4			Usual Occupations of working life. I			16b, Kind of	f Business/I	ndustry
0036 within 72 hour giene. ber than "natu E. Medical Exar ompleted	Elementary/Secondary (0-12)	4 years		ngura	nce Ag	ont		sel	f	
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p, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked niher than "natural", ar items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relations Arcella Hunt				Address (Street:					
and 2 sho ealth and 27 is con 27 is traumat	20a. Method of Disposition	er(prie			on (Name of ceme		Date			Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked niher than "natural", injury or ather traumatic event, the Medical Examiner To Be Completed by I	1 Burial 2 XCremation		Otate	natory or othe	rplace) cemator	0,00		   Pal+	imor	e, MD
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Examiner	Immediate Cause (Final disease or condition resulting in death)	a Contact Guns		f Head						Death
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5760 ficate is phys g phys s the by	IF FEMALE: 23b. Was decedent pregnant in the		come of pregnanc		death 3	Ectopic pregna	ancv	23d. Date Month	e of delivery	/ Day Year
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Mec Go With	29b. Signature and title of certifie	and manner state	d	<del></del>	29c. License	number		29d. Date s	igned (Mor	nth, Day, Year)
	Carol 1	talla	c-		O.C.M	.E.		August 6	5, 2012	
Jm.	30. Name and address of person	·		•	li C:	. De":	MD 04000			
V		Assistant Medical	Examiner S trar's Signature	YUU VV. Ba	iumore Stree	i, Baitimore,	, IVID 21223			
State Registrar		Berein	B. San	Kel						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 **Physician** 20<sup>Year</sup>2 Bernice Brown 5:50p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 2307 E. Hoffman St. Baltimore 8. Date of Birth (Month, Day, Year) 11/14/1930 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours New York 214-26-2699 81 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified N/A 1 Yes 2 No Director MID Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2307 E. Hoffman St. U.S.A. 21213 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **N**No 1 Never Married 2 Married 0 Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Seamstress Dan-Mar 7 Is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Bacon P Margaret Love 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Brown(daughter) 2307 E. Hoffman St., Baltimore, MD 21213 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-12 on-site Crematory 🔏 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Pineral Service Licenses 2140 N. Fulton Ave., Baltimore, MD 21217 Pirt1. Iter the disease shoc, or heart fri ure. ease, or complications that caused the death. re. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Fix I is a se or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 robably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2/2 No Other: 1 Tes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 atural 1 Yes 2 🗆 No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, or Attending Physician: s after death. filled in by the within 24 hours a Hospital

completely

Registrar

Medical

29a, Certifier

(Check only

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

32. Registrar's Signature AUG 1 4 2012

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

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The standard of the standard o	. Bo he dear	Phys		esulting in the	underlying cause	given in Part I	23e Did to	bacco use c	ontribute to t	ne cause of death?
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29b. Signature and title of certifier  29c. License number O.C.M.E.  August 1, 2012  30. Nahe and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		dical	one) 2 Medical Examiner: On the basis of examination a	_						
30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	9 1 × 1 8	Me			29c. Licen:	se number		29d. Date s	signed (Mon	th, Day, Year)
Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year) 732. Registrar's Signature	_/		Humaly mohally MD		O.C.	.M.E.		August	1, 2012	
State 31. Date filed (Month, Day, Year) /32. Registrar's Signature	y				0 W. Baltimor	re Street, Balt	imore, MD 21	223		
			31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ure						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1.55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 1-test the Core Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 214-12-8555 1 XM 2 - F 89 Days Hours Min (Month. Yrs. Country) MARY LAND **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director event, the Medical Examiner must be notified BALTIMORE PIKESVILLE MD. 1 X Yes 2 □ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 130 SLADE AVE 21208 USA 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces'
1 Yes 2 If Yes, Give
Year or Dates. ö by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: BLACK 'natural", Completed 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) MAIL CARRIER POSTAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ IRVING BROWN MABLE WARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is DORIS RANDOLPH(COUSIN) 130 SLADE AVE. PIKESVILLE, MARYLAND 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō cemetery, crematory or other place) injury GARRISON FOREST VETERANS 8-16-2012 OWINGS MILLS, MARYLAND D. HIBNER. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. JONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Onsetvin Deat Physician. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for المعالمة Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No □ Yes Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of After this certificate has page 2 autopsy performed Yes 2 death? 1 Yes 2 No Be 25. Was case referred to medical in by the funeral director, 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Tes 2 No after death Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 To the I within 2 only one 29b. Signature and title of certifier

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State Registrar 31. Date filed (Month, Day, Year)

AUG 1

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DANG

Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

Donald Caldwell

			Pleas	e Type or Pri							gible.	
		-	For State Registrar	State of Ma	aryıan	-	artment of H tificate of D			eg. No.	01:	2 2577
	Physicia	n/	1. Decedent's Name (First, Middle, L.	,					Date of Deal     Month	Day	Year	3. Time of Death
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~~	Funeral			Sex _ 7. Age		ast birthday)	ROSC (1	If Under 24 Hrs.	8. Date of Birth		9. Birt!	nplace (State or Foreign
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	yland f show ed at	ģ	10a. State 10b. County			y, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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	r death		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	12. Was Decedent E		S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White	ican Indian, , etc.
21215-0036	rs afte rral", c Exam	ed by	3 ₩ Widowed 4 Divorced	1 Ves 2 If Yes, Give Year or Dates 1	944-1	991	1 ☐ Yes 2.☐XNo	Specify:		Spec	eify: wh	ite
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mo m	Page 1 ment of ant: If it ury or o		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	C	emetery, crer Laney	natory or other plac		5. 2012			Maryland
Baltimore, Maryland	permit. Page 1 Department of Important: If i any injury or of once.		21. Signature of Timeral Service Lice	nsee	1 Dui							eral HomeIn
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Box 68760	eath certificate be attending physici for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	al death 3	☐ Ectopic pregnand ☐ Other (specify)	Э		23d.	Date of del Month	ivery Day Year
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Division of Vital Records,	To the Hospital or Attending Physician: whithin 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 6 Could no 4 Homicide determine	be 280 Place of Init			reet, factory, office		28f. Location (S City or Tow		mber or Ru	ral Route Number,
۵	spital o	Medical C	29a. Certifier 1 Certifying P	hysician: To the best of	my know	ledge, death	occured at the time	, date and place, a	nd due to the cau	se(s) and m	anner as sta	ated.
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	11		30. Name and address of person who	11 11-	11100	111	rint)	OIA	lain	-11	7	_ (	7	10	201 127/ma	-76-0
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	Registra	ar	AUG 1 4 2012	Clever	p. 12	gares										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month P narle 500 80 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 19,1940 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) **Funeral** 1 ▼ M 2 □ F 204-30-3561 72 Vre Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Sparrows Point Director 1 ☐ Yes 2X No with the 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or iral", or Items 23a o Examiner must be 2513 North Snyder Ave. 21219 LISA Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 years Dve Setter Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Cassidy Virginia Hull ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Gilley Daughter 82 Cox Road, Colora, Maryland 21917 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Foneral S-wire Lin 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1 Approximate Interval Between shock, or heart failure. List only one cause on each line. me te Cause (Final Onset and Death Preumon **Physician** se or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PSi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed physician and as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 🗌 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 2 No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed build be de 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 TYes 2 No 3 □ Probably 4 □ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page certificate 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \sum \) Nursing Home 1 ☐ Yes 2 No 1 Anpatient 2 ER/Outpatient 3 □ DOA မ 5 Residence 6 Other (Specify) this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 2 Accident 1 🗌 Yes 2 🗌 No the 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 🗌 Homicide City or Town, State) the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

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State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YANG

29c. License number

RES-OUT

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

			For State of M	laryland / Depa	artment of Health and	Mental Hygie	ne
	Dhysiois	m/	Registrar  1. Decedent's Name (First, Middle, Last)	061	Timeate of Death	2. Date of Death Month	3. Time of Death
	Physicia Medic	cal	LILIANA P. CICCANTI  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Deatl	AUGUST	8 2012 4130 M
	Examir		But Air Health and Rehabilitation	on lenter	BEI AIT		4c. County of Death HARFORS
	Funeral Director			79 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 2-25-193	Birthplace (State or Foreign
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	the Ma or 28; e notif	Dire	10e. Street and Number		10f. Zip Code	10g.	. Citizen of What Country?
	h with 1s 23a nust b	Funeral	8907 JASPER LANE		21234		USA
21215-0036	filed within 72 hours after death with the Maryland theylone.  4 Hygiene.  4 other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ▼ Widowed 4 ☐ Divorced  12. Was Decedent Armed Forces?  1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	<b>K</b> No .	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 【 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
15-(	72 ho	mple	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of wor O NOT use retired)	king 16t	o. Kind of Business/Industry
212	ed within Hygiene. other than ent, the M		Elementary/Secondary (0-12) College (1-4 or secondary 4TH	D+)	EAMSTRESS		TAILOR
ਰ	ould be filed d Mental Hy marked oth matic event	To Be	17. Father's Name (First, Middle, Last)  EMIDIO PICCIONE			ne (First, Middle, Maid TA ARMILLE	•
	2 shou h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)  CESARE CICCANTI . JR.		ng Address (Street and Number or Ru	ral Route Number, City	
_	ge 1 and 2		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cren	osition (Name of matory or other place)	Date 200	c. Location - City or Town, State
ltim	permit. Page 1 Department of Important: If is any injury or of		4 Donation 5 Other (Specify)  21. Signature of Euneral Service Licensee	PARKWOOD	8-1. 2. Name and Address of Facility SC		ARKVILLE, MD. NERAL HOME, INC.
B	Dep Imp any		XXX SIGH		9705 BELAIR ROAD		AM, MD. 21236
	Medical an and tial-transit	Examiner	Sequentially list conditions, If any leading to harmodat cause. Enter Underlying Cause (Disease or injury that initiated events  c.	a consequence of):	conditioning Dementia		Approximate Interval Between Onset and Death
0	E iii e	ical	resulting in death) Last Due to (or as	a consequence of):			
. Box 6876	requires that the death certificate been signed by the attending phys should be detached for use as the		23c. If yes, outcome   23c. If yes, outcome   1	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ls, P.O.	n signed by	by	Part II. Other significant conditions contributing to death b	out not resulting in the u	ınderlying cause given in Part I.		co use contribute to the cause of death?
Division of Vital Records,	rne raw ate has page 2	Completed				24a. Was an autopsy performed 1  Yes 2	
/ital	certificate	m	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:		26. Place of Death (Che		- T - W - W - W - W - W - W - W - W - W
n of \	ding Priy	cate: To	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation			28d. Describe how in	e 6 Other (Specify)
Divisio	ure nospina or Attending Frinsicali: within 24 hours after death.  To the Funeral Directors After this certificacompletely filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be	ury - At home, farm, stre c. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
_ :	n 24 hour n 24 hour ne Funera	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practitioner: To the	examination and/or invest	tigation, in my opinion, death occurred	at the time, date and pla	ace, and due to the cause(s) and manner stated.
	Within 2  To the I		29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
	GM		30. Name and address of person who compared cause of d	leath (Item 23a) (Type, F	erto Are. Ste.	101 Ros	Ar, MD 21014
F	Stat Registra			ar's Signature	Kel	, je	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Sophie Rose Dobrz	ynski State of Maryland / De	epartment of Health and Mental H Certificate of Death		2 257						
Physician/ Medical Examine	Decedent's Name (First, Middle, Last)     Sophia Rose Dobrzynski		2. Date of Death Month Day Year August 5, 2012	3. Time of Death 1517 hrs						
	Facility Name (if not institution, give street and number)     Peninsula Regional Medical Center	4b. City, Town, or Location of Death Salisbury		n						
Funeral Director	175-80-2363 <sub>1□M 2</sub> 11	yrs. last birthday)   If Under 1 Year   If Under 24Hrs   Months   Days   Hours   Mir	07/12/2001 Foreig	thplace (State or gn puntry) PA						
hours after death with the Maryland "natural", or items 23a or 28a-f show any Examiner must be notified at once. God by Funeral Director		If Yes, specify Cuban, Mexican, Puerto		10d. Inside City Limits 1 ∑Yes 2 No ntry? ican Indian, Black,						
5-0036 led within 72 hours after of they within 72 hours after of other than "natural", of the Medical Examiner of Completed by F.	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12)  College (1-4 or 5+)	id) 1 Yes 2 No specify:  id) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done   16b. Kind of Business/lired)   Middle Sc							
121() ld be fill Aental I Aental I ceent, o Be	17. Father's Name (First, Middle, Last) Charles S. Dobrzynski, III  19a. Informant's Name/Relationship (Type, Print)	Tabitha  19b. Mailing Address (Street and Number or I	•	,						
nore, MD 2 ages I and 2 shou nnt of Health and A nt. Hitem 27 is n other traumatic	1 XXBurial 2 Cremation 3 Removal from State	620 Constitution Blv	rd New Kensington, F Date 20c. Location - City or 10/2012 Natrona He	Town, State						
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr	Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  Mullaul P. Maryulli  Mary	6009 Harford Road	zullo Funeral Chap Baltimore, Maryla	pel, P.A. and 21214						
Physician IMadical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):  Sequentially list conditions,									
e executed Sian and rial - transit <b>Jical Examiner</b>	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence of the cause)  Due to (or as a consequence of the cause)		)							
Records, P.O. Box 68760, The law requires that the death certificate be executed in the law requires that the death certificate be executed in the base has been signed by the attending physician and page 2 should be detached for use as the burial - transcription of the completed by Physician/Medical	UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown  AMENDED 1 as 1  23c. If yes, outcome of p  1 Live birth  4  Pregnant at time of p  9  Unknown	pregnancy 2 Fetal death 3 Ectopic pregna	23d. Date of delivery	/ Day Year						
P.C es that ligned 1 by	Part II. Other significant conditions contributing to death but n	not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to 1  Yes 2  No 3  Prob	pably 4 Unknown						
tal Records, cian: The law requirection: The law requirection of certificate has been signed to page 2 should be Be Completed			autopsy prior to death?  1 ✓ Yes 2 No 1 ✓ Yes	topsy findings available completion of cause of s 2 No						
f Vital Physician: Physician: er this certi ral director To Be	27 Manner of Doath 282 Date of Injury	26.Place of Death (Check  26.Place of Death (Check  Other4 Nursin  28b. Time of Injury  28c. Injury at Work?	only one)  ng Home 5 Residence 6 Other  28d. Describe how injury occurred	:						
	1 Natural 5 Pending FOUND: Aug 5, 2012	FOUND: 1 Yes 2 No 1431 hrs  At home, farm, street, factory, office building, etc.	Ejected passenger during auto 28f. Location (Street and Number or Ru or Town, State) Route 50 Bypass, Salisbury, Md.							
Divis  To the Hospital or At within 24 hours after d  To the Funeral Direct completely filled in by Medical Certifics	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	wledge, death occurred at the time, date and place, and on and/or investigation, in my opinion, death occurred a	at the time, date and place, and due to the	e cause(s)						
≥	29b. Signature and title of certifier  20 Name and address of paragraphic completed are so of death (	29c. License number O.C.M.E.	29d. Date signed (Mor August 6, 2012	nth, Day,Year)						
⟨ρ V State	30. Name and address of person who completed cause of death (I Ling Li, MD, Assistant Medical Examiner 90 31. Date filed (Morth 1977, Par) 32 Registrar's Sign	00 W. Baltimore Street, Baltimore, MD 21	223							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time o Death Month Physician/ 12:16A M Obor 2012 lugust Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Raltimore oniter TOUSON 1christ If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Funeral Days 1 M 2 □ F Director Jul 06, 1928 Maryland ir than "natural", or items 23a or 28a-f show the Missis Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pege 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21210 Roland Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Year or Dates. UUII White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Electrical/Defense **Engineer** other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Helen Bernadette McDonough George Gray Dryden of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Dryden /Daughter 4546 Keswick Rd. Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō <u>=</u> permit. Pege 1 Department of Important: If it any injury or o cemetery, crematory or other place 1 Durial 2 Cremation 3 Removal from State Aug 4 ☐ Donation 5 ☐ Other (Specify) 2012 Beltsville, Maryland Chesapeake Cremator 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service License 401585 Green Pastures Drive Towson Maryland 21296 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ PAR VANCOD disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury attending physician end for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) ☐ Yes 2 ☐ No cate has been signed by the a page 2 should be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? COREWARY ARTERY DISCASE 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of deuse of death? 24a. Was an autopsy performed PROSTATE 1 ☐ Yes 2 ☑ No Yes 2 After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) in by the funeral director, Be lospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2- No ٥ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending s after death. 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

within 24 hours aft

To the Funeral Dir

completely filled in

State Registrar 29a. Certifier

no completed cause of death (Item 23a) (Type, Print)

32. Registra

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b, c per fh g930 8-21-12 vt

		_	For State	State of Maryland / De			Mental Hygie	ene	
			Registrar  1. Decedent's Name (First, Middle, Last)	(	Certificate of D	eatn		3. No. 20	12 25778
	Physicia		Alice	V •	Dill	<u>L</u>	2. Date of Death Month	09 201	ar 3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give str	eet and number)	4b. City, Town, or	Location of Death	08	4c. County of D	
	LAdimi	CI	Courtland Garden			esville			imore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthd		If Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign
	Director			M 2X□F 93 Yr	Months Days	Hours Min.	(Month, Day, You 12 25	18	Country) MD
	ov pt	_	Usual Residence of Decedent  10a, State  10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	arylar a-f st fied a	) St 	MD NA		imore				Yes 2 No
	or 28	ğ	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	
	with t	Funeral Director	1309 West Sarago	ta Street		223		U.S	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at once.	Be Completed by Fun	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 N No If Yes, Give Year or Dates.	13. Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc. lack
5-0	2 hou	plet	15. Decedent's Educ (Specify only highest grade		ecedent's Usual Occupa Give kind of work done do	ition	ing 10	6b. Kind of Busine	ess/Industry
121	thin 7	ĕ	Elementary/Secondary (0-12) 12thgrade		fe. DO NOT use retired) Domestic		9	Priv	ate
D	ed wil	e e	17. Father's Name (First, Middle, Last)	114			- /5:-> 8 4:-4-1- 8 4-		
an	be file ental ked c	힏	Wilson Benson		İ		e (First, Middle, Ma Waters	iden Surname)	
ary	nd Mi		19a. Informant's Name/Relationship (Type	Print) 19b. N	Mailing Address (Street a	nd Number or Rum	al Boute Number C	ity or Town State	Zin Code)
Σ	id 2 sl alth a n 27 la		Doris McCleod-Da	ughter 54	Mailing Address (Street a Loomis Ci	t., Owi	ngs Mil	ľs, Mď	21117
Baltimore, Maryland 21215-0036	Page 1 ar tment of He tant: If iten jury or oth		20a. Method of Disposition 1   Burial 2  Cremation 3  Re 4  Donation 5  Other (Specify)	moval from State Draggetry,	isposition (Name of Rickers of Chinese of Ch	erv :	l D	oc. Location - City	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee	Kake	22. Name and Address March F/H 4300 Waba	s of Facility West sh Ave,	Baltim	ore, Mo	21215
			23a. Part 1. Enter the disease, or complic shock, or hear vailure. List only one	cause on each line.	À -			,	Approximate Interval Between
	Pnysician/		Immediate Cause (Final disease or condition	Cerebrol	c50 ula 1	geery	Liel		Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequence of)		. 62 .	m		
		ē	Sequentially list conditions, b.	Due to (of as a consequence of),		0240	and		
T	ted	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	but to for as a consequence sig.					
	icate be executed physician and is the burial-transi	EX	that initiated events c. resulting in death) Last	Due to (or as a consequence of)				<del> </del>	
0	s be e ysicia e bur	ical	d.						
876			IF FEMALE:					7 A	
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	If yes, outcome of pregnancy	3	,		23d. Date of Month	f delivery Day Year
9. 0.	that the ned by deta	y P	Part II. Other significant conditions control	ibuting to death but not resulting in	the underlying cause give	en in Part I.	23e. Did toba	cco use contribut	e to the cause of death?
s,	n sign	pa pa	ESSENTER	7 HADEV	tens, oa	1	1 ☐ Yes	2 3	Probably 4 Unknown
500	w red s bee 2 sho	plet	Octobar	11/1/2			24a. Was an	24b. Were	autopsy findings available
žec	The la	E O	Ortenbus	2175			autopsy performe 1 🗌 Yes 2	ed? death	to completion of cause of h? Yes 2 \sum No
ā	ian: ] artifica ctor, j	Be	25. Was case referred to medical examiner?		26. Pla	ce of Death ( ec	- 71	No.	163 2 63 140
₹	hysic his ce al dire	힏	1 ☐ Yes 2 ☐ No Ho	spital: 1  lnpatient 2  ER/Outp	atient 3 DOA Othe	r: 4 Nursing Ho	ome 5 Residen	ce 6 Other (S)	pecify)
ion of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, pege 2	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury 28b. Tin (Month, Day, Year) inju	y work?		28d. Describe how	injury occurred	
Divis	ital or Att irs after d al Direct led in by		4  Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)			City or Town, S	State)	Rural Route Number,
	he Hosp iin 24 hou he Funei ipletely fi	Medical	(Check 2 ∟ Medical Examine:	an: To the best of my knowledge, de On the basis of examination and/or in Practitioner: To the best of my knowle	nvestigation, in my opinio	n, death occurred a	t the time, date and a	place, and due to t	the cause(s) and manner stated
ر _	Viit To 1		29b. Signature and title of certifier	/ - 1	29c. License	number	290	d. Date signed (Mo	onth, Day, Year)
	111		1000	mergoon	10 1	4175		31101	2015
	90		30. Name and address of person who com  31. Date filed (Month, Day, Year)	out low	pe, Print)	Jule	300	1),10	es alle YV
	Sta Registra		AUG 1 4 2012 Z	32. Registrar's Signature	4				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8-7-2012 Day Physician/ 4:10A M FRANCES DIETSCH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A FUTURE CARE CANTON HARBOR 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Hours Director 215-14-5875 1 M 2 X F 92 Yrs MARYLAND 10-21-1919 10b. Count 10d. Inside City Limits 10c. City, Town or Location Directo BALTIMORE MD. X☐ Yes 2☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21224 310 IMLA STREET 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 Å No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, e ģ 1 Never Married 2 Married WHITE Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DEPT. STORES DEMONSTRATOR 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ JULIANNA POWERS LESCO REMENIUK 1 and 2 should be Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD. 21224 1201 S. ELLWOOD AVENUE LORETTA STACHOWSKI DTR Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-10-2012 BALTIMORE, MD. OAKLAWN CEMETERY 21. Signature of Funeral Service Livensed 22. Name and Address of Facility CHARLES S. ZEILER & SON INC. BALTO.MD. EASTERN AVENUE that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complications Approximate Interval Between Onset and Death Part 1) Enter the disease, or complications the shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition ONGE Pnysician Medical resulting in death) Due to (or a consequence of) Examiner Aortic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami erat Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the human completely filled in by the funeral director, page 2 should be detached for use as the human completely filled in by the funeral director, page 2 should be detached for use as the human completely filled in by the funeral director, page 2 should be detached for use as the human completely filled in by the funeral director, page 2 should be detached for use as the human completely filled in by the funeral director. Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) ☐ Yes 2 ☐ No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 5 Pending 2 🗌 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Deficiency Continuous Conti 29a. Certifier only one) 29d. Date signed (Month, Day, Year) 10 8 who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lester Dimeler, Jr. Month Day 12: Medical Anu 43 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2022 Grinnalds Ave. Baltimore City Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Days Hours (Month, Day, Year) 1 M 2 □ F Director 218-62-9212 58 Yrs. 15, 1954 June Maryland Usual Residence of Decedent or 28e-f shov 10a. State 10c. City, Town or Location 10b. County treumetic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore City 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 239 2022 Grinnalds Ave. 21230 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) el Hygiene. d other then ' Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse 12th Lahorer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Heelth end Mentel Hoftem 27 is merked of Item 27 is merked of rother treumetic even မ <u>Lester Joseph Dimeler, Sr.</u> Carolyn Fern Wheatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Dimeler/ Wife 2022 Grinnalds Ave., Baltimore, Maryland 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit, Pege 1 Depertment of Importent: If i any injury or o 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Atlantic Crematory 10,2012 Aug. Glen Burnie, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility
AMBROSE FUNERAL HOME OF LANSDOWNE
2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Malignant melanoma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ettending physicien end for use es the burial-trensit auss (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death Month To the Hospitel or Attending Physicien: The lew requires thet the dea within 24 hours effer death.
with have effer death.
The Funerel Director: Affer this certificate hes been signed by the a completely filled in by the funerel director, page 2 should be deteched P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed: 1 Yes 2 No ☐ Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier nothing applicano 8/9/12 M21709 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 WSKajapaksemp Day, Year) 31. Date filed (Month State AUG 1 4 2012 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Rennie Ellis 2012 2578 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death ecedent's Name (First, Middle,Last) Physician/ Month Day July 31, 2012 2230 hrs **Medical Examiner** ennie 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 314 East Lafayette Avenue 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or 5. Social Security Number **Funeral** Foreign Months Days Hours Director 2/28 Country) 60 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County Yes 2 No or items 23a or 28a-f show must be notified at once. ore ies I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Director 10g. Citizen of What Country 21202 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Yes è Specify: Black Divorced f Yes. Give Year Yes 2 No specify: "natural" ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) If item 27 is marked other than 21215-0036 18. Mother's Name (First, Middle, Maid Gan æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Devoted **M** Balto, MD Friend 20b. Place of Disposition (Name of cemeter crematory or other place) or other Burial Cremation 3 Removal from State 2 Baltimore, permit. Page: Department o 1D 2012 rtant: Donation Other Specify uneral Gervice Licenses OIE. North Baltimore Approximate Interva Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical attending physician for use as the burial -AMENDED UNPENDED Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions 2 1 Yes 2 No 3 Probably 4 ✔ Unknown **Diabetes Mellitus** Completed Records, 24a Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy performe death? page Yes 2 ✔ No Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be of Vital examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗸 Other: Scene 2[ ER/Outpatient 3 DOA After this 1 🗸 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a, Date of Injury (Month, Day, Year) 28b. Time of Injury Manner of Death Certification: Division 1 V Natural 1 Yes 2 No Pending Director: I in by the f Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 10, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month) 1°4°2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#20a-c, 22perFH, G931, 9719, 2012, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2012 8:10 August Bernard Francis Ford Sr. 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death

Clinton

Ам

Prince Georges

Physician/ Medical Examiner

For State Registrar

Southern Maryland Hospital

**Funeral** Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

al	5. Social Security Number 6. Sex	80	Months Days	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplac Country)	e (State or Foreign								
or	579-44-1689 1 ☑ Usual Residence of Decedent	M 2 □ F   80 Y	/rs.		Feb 5, 193	2 Mary	land								
호	405 0	10c. City, Town	or Location		10d.	Inside City Limits									
irec	MD Prince	Georges Clin				1 Yes 2 No									
Funeral Director	10e. Street and Number 9211 Stuart Lane	<u> </u>	10f. Zip Code 20735			itizen of What Country USA	,								
Fu	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spec Mexican, Puerto F	cify Yes or No- Rican, etc.)	Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc.									
Completed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No		Specify: Blac	k									
plete	15. Decedent's Edu (Specify only highest grade	Kind of Business/Indus Department													
		Agricultur													
o Be		17. Father's Name (First, Middle, Last)  Joe Ford  18. Mother's Name (First, Middle, Maiden Surmame) unk													
욘															
	19a. Informant's Name/Relationship (Type, Print) Betty Ekhartor – daughter  19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 5362 Quincy Place #202; Hyattsville, MD 20784														
	20a. Method of Disposition	1 Rurial 2 M Cremation 3 Removal from State   cemetery, crematory or other place)													
,	4 Donation 5 Street (Specify)*	in state Chesap	eake Cremato	ry 9/19	/2012 Bel	tsville, M	D								
ouce	21. Si pratrie of Euri   Servi Licens   Rona I	Director	Johnson & J	enkins F	uneral Hom 11; Baltim	ore, MD 21	nedy St Nw <del>201</del>								
	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ications that caused the death. Do no	ot enter the mode of dying,	such as cardiac of	r respiratory arrest,	A Ir	pproximate iterval Between								
V	Immediate Cause (Final disease or condition	a. Aspiration	C	Inset and Death											
al er	resulting in death)  Due to (or as a consequence of):														
iner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Disease or injury that initiated events are this included by a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):														
xam															
calE	resulting in death) Last  Due to (or as a consequence of):														
Medi	IE EEMALE:	J													
ted by Physician/Medical Examiner	23b, Was decedent pregnant in the past 12 months?  1	in the past 12 months?  1													
× Ph	Part II. Other significant conditions con	use contribute to the	_												
ted b	2	2 ☐ No 3 ☐ Froba	Probably 4 Unknown												
Complet	5	24b. Were autops prior to comp death?	autopsy findings available to completion of cause of n?												
		No 1 ☐ Yes 2	□ No												
cate: To Be	examiner?	Hospital:	Othor	ce of Death (Check	me 5 Residence	6 ☐ Other (Specify)									
		27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury work 1 Natural 5 Pending 28c. Injury at work 28													
Certificate:		28e. Place of Injury - At home, far building, etc. (Specify)	and Number or Rural R te)	oute Number,											
Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examinonly one) 3 Certifying Nurse	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state.													
	29b. Signature and title of certifier	29b. Signature and title of certifier  (Mo 29c. License number  (Mo 8-8-													
	30. Name and address of person who co	ompleted cause of death (Item 23a) (	Type, Print) 750/	old Bro	anch Ave	2 # 409									
	Khoscow Daver	32. Registrar's Signature	Clin	iton is	nd 207	3)									

Registrar

AME	ND	#25, PER	Please ME G930	Type or Pr 8/8/12 TR	int in Blac	k Indelik	ole ink	<b>c. Ens</b> u	ure A	II Copie	s Are	e Legible	e.		
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Medic	al .		n Matthew							August					
Examin	er			e street and number)		4b. Cit		Location o			40	c. County of De Howa			
		Valley 5. Social Security N		Sey 7 A	ge (In yrs. last birt	hdav) If Und	er 1 Year	Licott		8. Date of Bi	rth		Birthplace (State or Foreign		
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or it	by F		ried 2 Married	Armed Forces	? No					Rican, etc.)		Black, Wh			
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within 72 hours after giene. er than "natural", o ; the Medical Exam	Completed	(Sp	15. Decedent's l ecify only highest g		16a.	16a. Decedent's Usual Occupation (Give kind of work done during most of working						16b. Kind of Business/Industry			
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<b>6</b> d al ==	101		on Hamilt				H	elen	E. Fo	rd	iden Surname)				
1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's N	lame/Relationship (	Type, Print) AR	RC 198	o. Mailing Addre	ss (Street	and Numbe	er or Rura	l Route Numb	er, City o	or Town, State,	Zip Code)		
		Marcia	Koerner	- Represe	entative	11735	Home	wood :	Road	Elli	cott	City,	MD 21042		
ge 1 and it of Heal if item or other		20a. Method of Dis		Removal from State		of Disposition (N	ame of other plac	ce)		Date	1	-	or Town, State		
Page nent o			o 5 ☐ Other (Spec			coation	Com	1	8/9/	2012	C	linton,	Maryland		
permit. Page 1 and Department of Hee Important. If item any injury or othe once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH.  4112 Old Columbia Pike Ellicott City, MD 21										mily FH, Inc			
			neta K	thomas								tt CIty			
		shock, or he	art failure. List only	nplications that caus one cause on each li	ed the death. Do i ine.	not enter the mo	de of dyir	ig, such as	cardiac c	r respiratory a	irrest,		Approximate Interval Between Onset and Death		
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Medical Examiner		resulting in death)  Due to (or as a consequence of):								as Passel Floor					
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rou cate be executed physician and s the burial-transit	Ä	that initiated events resulting in death) Last Due to (or as a consequence of):							TOONED BY MEDICAL EXAMINER						
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is that the dea signed by the a be detached to	Completed by Physician/Medica			contributing to death	n but not resulting	in the underlyir	g cause g	iven in Part	1.	23e. Did	tobacco	use contribute	e to the cause of death?		
signe		RESPIRATORY FAILURE								1 Yes 2 No 3 Probably 4 Unknow					
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The law ate has page 2:	E G	QUIN STONE COOP 7111							-	autopsy performed?  1 □ Yes 2 □ No  autopsy performed?  1 □ Yes 2 □ No					
sician: The certificate irector, pag	ပို	25. Was case refe	rred to edical	26. Place of Death (Check only one)											
rsicia s cert direct	To Be	examiner?	110	Hospital:	tient 2  ER/Outpatient 3  DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
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on endin eath. or: Aft he fur	Certificate:	1 Natural 2 Accident	5 ☐ Pending Investigati 6 ☐ Could not	MM		Yes 2	] No								
LIVISION OT VITAI al or Attending Physician: 's after death. al Director: After this certific ed in by the funeral director	erti	3 Suicide 4 Homicide	arm, street, fact	reet, factory, office 28f. Location City or T					(Street and Number or Rural Route Number, own, State)						
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To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check	2 Modical Eva	nysician: To the best miner: On the basis o urse Practitioner: To	of examination and	or investigation.	in my opin	ion, death o	occurred a	t the time, date	e and pla	ce, and due to t	the cause(s) and manner sta		
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Ran		30. Name and ad	dress of person who	o completed cause o	of death (Item 23a)	(Type, Print)	_		-0	<u> </u>					
00		DAVID	LEICH	TLING	5450	KNOL	LN	DR	. C	OLU	MB	MA M	0 21045		
	ate	31. Date filed (Mo			strar's Signature	1	P								
Regist	rar		AHE 1 9 2	1012 /	and a M	Barre	Sitter								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARVIN V. FISHER 8/9/2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 5820 EBENEZER ROAD WHITE MARSH BALTO. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 217-26-5139 1**X** M 2 □ F 83 Director MARYLAND JULY 2,1929 Usual Residence of Decedent "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director WHITE MARSH 1 Yes 2X No MD BALTO. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5820 EBENEZER ROAD 21162 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc Armed Porces: 1 Yes 2 No If Tes, Give Year or Dates. 1948–1953 þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry BALTIMORE COUNTY (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) POLICE DEPARTMENT **SERGEANT** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MAY VINCENT ၉ HENRY FISHER Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Health a 5820 EBENEZER ROAD WHITE MARSH, MD. 21162 RUTH J. FISHER SPOUSE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 6 1 Burial 2 Cremation 3 Removal from State Important: If any injury or once, 4 Dogation 5 Other (Specify) ENTOMBMENT 8-13-2012 MIDDLE RIVER, MD. HOLLY HILL 21. Signatu/ of Funer SCHIMUNEK FUNERAL HOME, INC. 22. Name and Address of Facility 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. P. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or lear failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Physician/ disease or condition resulting in death) month Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): il or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and Cause (Disease or injury ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De th Natural 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d Describe how injury occurred 5 Pending 1 Yes Accident 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours To the Funeral I Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medibal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 3 (certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of per 29d. Date signed (Month, Day, Year)

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State

Registrar
DHMH 17 Rev 06-2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Fagistr

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BALTIHORE

MALE AVE

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		For State		State o	aryland /	and M	Mental Hygiene										
		Registrar  1. Decedent's Name	e (First, Middle,	Last)		Certificate of Death					Reg. No. 2. Date of Death 3. Time of Death						
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Examin	er	4a. Facility Name (if	YLAND			545	IEM	4b. City, Town, o	PEAR)	f Death	DINT	4	c. County	of Death	ELL		
Funeral Director	0	5. Social Security No. 225–34–96		6. Sex 1 ☑ M 2 ☐ F	7. Age	(In yrs. last b	virthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min	8. Date of B	irth ay Year, 20	1931		hplace (State		
nd how at	ř	Usual Residence of 10a. State	Decedent 10b. County			10c. City, To	wn or Loc	cation							10d. Inside C	city Limits	
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ems 2	une	11. Marital Status		12. Was Dece	dent E	nt Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes?)  If Yes, specify Cuban, Mexican, Puerto Rican,							SA L <sub>14. Bace</sub>	e - Amer	ican Indian,		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)  Sharon L. Fries-Britt / Daughter 10603 Foxlake Drive, Bowie, Maryland 2									tate, Zip	Code)					
1 and of Heal item 2		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or															
Page ment c tant: If jury or		1 Description 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify)  Darlington Cemetery 8-16-2012.  Darlington										Land					
permit Depari Impor any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A.  1317 Cokesbury Road, Abingdon, Maryland 210												1009			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between													ite		
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the b.	Physician/Medical	23b. Was decedent in the past 12 r 1 Yes 2	Ectopic pregnand Other (specify)	су				23d. Date of delivery  Month Day Year									
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Hospi 24 hou Funer eted fill	Medical	(Check 2	Medical Ex	Physician: To the b	is of ex	amination and	Vor investi	igation, in my opinio	on, death occ	curred at t	he time, date	and plac	e, and due	to the ca	ause(s) and ma	anner stated	
To the within To the compl	Σ	only one) 3 29b. Sonature and	_	Nurse Practioner:	io the t	best of my kno	wieage, a	29c. License		PA <	state				Day, Year)		
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10,0		30. Name and addre	ess of person w	ho completed caus	e of de	eath (Item 23a)	(Type, P	AND HEA	ALTH E	ARE	SYST	FM,	PEAR	Y PO	INT. M	1 1903	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 10 20 Î 2 8:25 Helen Η. Finlayson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Gaithersburg Asbury Wilson Health Care Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Maryland October 24, 1924 87 220-18-8254 **Director** Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10d Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 United States 301 Russell Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Adele Dorsey John Leonard Hoffman, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8014 Kiwi Point, Tega Cay, South Carolina 29708 James M. Fulks / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) August 2012 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 14, Montgomery Crematorium, Inc Bethesda, Maryland 4 Donation 5 Other (Specify) Robert A. Fumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licenses Mosselle M01305 Paff 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final disease or condition Physician/ Chronic Renal Failure Medical resulting in death) Due to (or as a consequence of): **Examiner** Dementia End Stage Sequentially list conditions, Examiner Due to jor as a consequence of cause. Enter Underlying Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🔲 No this certificate 1 Yes 2 X No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛣 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) August 10, 2012 D20148 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 911 Russell Avenue, Gaithersburg, Maryland 20877 Steven Dolinsky, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 4 2012

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 3,2012 9:05 A<sub>M</sub> Allen Thomas Fisher, Sr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Healthcare Genesis 8. Date of Birth (Month, Day, June 26, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. Maryland 219-56-5667 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 □ Yes 2 ▼ No Federalsburg Maryland | Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21632 218 S. Main Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. White 1 Never Married 2 Married 1 ☐ Yes 2XXIIo If Yes, Give Ye ar or Dates: Specify. Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Manual Labor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Mae Brown Charles Other Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10804 Bristow Rd., Bristow, Virginia 20136 Allen T. Fisher, Jr. / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Aug. 9,2012 Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ROSE FUNERAL HOME, INC. re of Poheral Service Licen ather 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Day in the past 12 months? 1 □ Yes 2 □ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 ☐ Yes 26. Place of Death (Check only one) Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar physician at the burial Division of Vital Records, P.O. Box 68760, attending p certificate has been signed by the rector, page 2 should be detached director, this After . after death.

Director: Af
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**Physician** 

/Medical

Examiner

**Funeral** 

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Exprining must be no once.

**Physician** /Medical

altimore, Maryland 21215-0036

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GOODSON OZ PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Northwist Randallstown Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Monith, Day, Year) Birthplace (State or Foreign Country) Director 1 DM 2 D Inia 27 is marked other than "naturei", or items 23a or 28a-1 shov traumatic event, tre Medical Examiner must be motified at 10b. County 10a, State 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry st grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last) မ 999 19a. Informant's Name/Relationship (Type, Print) Date Nter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth injury or other Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Department of I Important: If its any injury or of once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) butus 21. Signatura Funeral Service Licenses Hone, P. A se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pancreatic Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or Injury Due to (or as a consequence of): been signed by the attending physicien and should be detached for use as the burlal-transit Exami The lew requires that the deeth certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
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1 ☐ Yes 2 ☑ No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 s Director: After this certificate has autopsy 1 ☐ Yes 2 ☑ No Yes 2 No To the Hospital or Attending Physician: "within 24 hours efter death.

To the Funeral Director: After this certific. filled in by the funerel director. 25. Was case referred to medical B 26. Place of Death (Check only one) 2 A No Other: ဥ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation
6 Could not be 2 Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D65843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Court Road, Rondallstown, HD 21133

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Pear1 Goren 10:40 AM August 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Riderwood Assisted Living Silver Spring Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** Months Hours Director 98 050-09-1831 New Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD Prince George's 1 Yes XX No Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral #214 3152 Gracefield Rd. 20904 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Zimmerman Reichardt William Anna permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Goren / Son 605 Cedarcroft Rd., Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Chesapeake Crematory 08/13/2012 Beltsville, MD 4 Donation 5 Other (Specify) M00382 Rappe Fundral Failly Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 1 WEEK Death Physician/ ACUTE MYELOCYTIC LEUKEMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Day Year Pregnant at time of death Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 X No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) B B Other: 4 Nursing Home XX Residence 6 Other (Specify) 1 🗌 Yes Certificate: To 2**X**XN0 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred XX Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1XXcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check

State Registrar 3 🗆

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 1 4 2012

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALAN R. WEINSTOCK M.D., 10313 GEORGIA AVE., #105, SILVER SPRING, MD

32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D09748

29d. Date signed (Month, Day, Year) AUGUST 10, 2012

20902

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 9 Mary Theresa Gnall 6:00 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Healthcare Center Rising Sun 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe **Funeral** Months Hours (Month, Day, Year) 169-24-4450 Director 1 M 2 X F 91 Nov. 15. 1920 Pennsylvania 28a-f show 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f sho 10h County must be notified at Director 1 Yes 2 X No <u>Maryland</u> Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1881 Telegraph Road 21911 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed | 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary (nmn) Estock Michael (nmn) Popovich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 853 Broadfield Drive, Newark, Delaware 19713 Kathy Telep / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8-14<sup>Da</sup>2012 Page 1 permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 🗶 Removal from State George's Otho. Greek Cath. Cem. Taylor, Pennsylvania 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complication shock, or heart failure. List only one of Immediate Cause (Final disease or condition Physician/ ardiomyopathe Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 1 ☐ Yes ∠ ₩ 9 ☐ Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ementic 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 K 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 10 No မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After this certificate within 24 hours after deat To the Funeral Director. 2

State

Accident
Suicide

4 Homicide

(Check

29b. Signa

only one

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner To the best of my knowledge, earth

1 Yes

Prertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Nurse Practitioner. To the course only investigation are stated 29d. Date signed (Month, Day, Year)

Way Rising

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Investigation

determined

6 Could not be

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per ANA BD G930 8/14/2012 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month S 201 r<sub>M</sub> GANGLOFF 0 DWIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SILURA CROSS HOSPITAL SPRING MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Davs Hours Min. Country 297-12-9538 Director 1 **№** M 2 🗆 F New York Usual Residence of Decedent 28a-f show ıral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No MD JER SPRINC MONTGOMER 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 2090 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 😾 Yes 2 🗆 No 1943-Black, White, etc. þ 1 Never Married 2 Married 1 🙀 Yes 2 [ If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Widowed 4 Divorced Completed 1944 P permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Adminitrator of NIH scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gangloff 2 Esther Janet Studebaker Wilmer Charles Gangloff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CANGLOFF MAURINE OLD FORGE RD 20910 WIFE MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) atu e of Euneral Service Licens e 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Ph sician/ ARDIOPULMONAR? disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** PSis Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and the burial-transit BACTEREMIA requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical K Box 68760 as attending IF FEMALE: nse ( 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for L in the past 12 months? Month Day Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be CARCINOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? CANCER 24a, Was an BLADDE Hospital or Attending Physician: The law 1 24 hours after death.
 Funeral Director: After this certificate has t autopsy 2 No ☐ Yes 2 No 1 🗌 Yes Division of Vital completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Deatl 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 \( \text{Yes} \) 2 \( \text{No} \) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mil D 6410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITHA BHINKAI 1500 FOREST CI as as 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 4 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Carroll Hill 4:06 2012 10 Hugest /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Buthmore
If Under 1 Year If Under 24 Hrs. N/A Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Hours Min. **★**□ M 2□ F Days Yrs 212-58-6810 60 21.1952 | Maryland Director Heb. Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 28a-f show Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examinal must be retified at once. Yes 2□No N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Basement Apt. Pages 1 and 2 should be filed within 72 hours after death with 21216 USA 2108 W.North Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1% Yes 2 □ No Viet
If Yes, Give
Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 □ Yes 2 🖁 No Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Cary Hardware Elementary/Secondary (0-12) Maintenance 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk. Unk. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) \_ 21207 19a. Informant's Name/Relationship (Type. Print) 2817 Essex Road Windsor Mill, Maryland Vanessa Hill/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 8/15/12 Dundalk, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd Baltimore, MD 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) menth Physician Metastan /Medical Due to (or as a consequence of Examiner Garrontestin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed A cute blood loss
Due to (or as a consequence of): burial-trai Records, P.O. Box 68760. physician Physician/Medical thrombo 4 the attending p If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed has 2 No certificate 1 TYes Division of Vital the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 2 ER/Outpatient 3 DOA 1∐ Yes 1 Inpatient Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manny r of Death 28c. Injury at Work? After 1 Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Medical

29b. Signature and title of certific

COTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue

32. Registrar's Signature

timore MD

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Hanke, Barbara

			Please Type or Print in				_	_	jible.	
		-	For State of Maryla		artment of F rtificate of D		Mental Hy	21	012 25791	
	Dhysisis	n/	Registrar  1. Decedent's Name (First, Middle, Last)		timeate of E		2. Date of De		3. Time of Death	
	Physicia Medic	al	Barbara Ann Hanke  4a. Facility Name (if not institution, give street and number)	<del></del>	Ab City Town on	Lagation of Doot	Month		Year 10:39 AM	
أركم	Examin		Franklin Square Hospita	(	4b. City, Town, or ROSE	y of Death Himore				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (in yrs 213 88 2487 1 □ M 2 🛂 5 51	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	ay, Year)	Birthplace (State or Foreign Country)	
			Usual Residence of Decedent	Yrs. Dity, Town or Lo	antin a		1961	Maryland		
/arvlan	8a-f sh tified a	Director	Maryland Harford	-	l Air			10d. Inside City Limits 1 ☐ Yes 2 🛣No		
th the h	3a or 2 t be no		10e. Street and Number 2118 Northridge Drive		10f. Zip Code	15		g. Citizen of What Country?		
eath w	tems 2 er mus	Funeral	11. Marital Status 12. Was Decedent Ever in U		21015 USA  13. Was Decedent of Hispanic Origin? (Specify Yes or No-  14. Race - American Indian,					
<b>1036</b> rs after de	be filed within 72 hours after death with the Maryland with Hygiene 1. And whaturally, or items 23a or 28a-f sho ked other than "naturally, or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	- 1	If Yes, specify Cubar 1 ☐ Yes 2 🏞 No		to Rican, etc.)	Blac	ck, White, etc. : White	
Maryland 21215-0036 2 should be filed within 72 hours after	n "natu Aedica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d O NOT use retired)	ation luring most of wo	rking	16b. Kind of B	Business/Industry	
212 within	ygiene. her tha t, the N		Elementary/Secondary (0-12) College (1-4 or 5+)		ales Cler	k		Ret	ail	
and be filed	red off	To Be	17. Father's Name (First, Middle, Last) Unk. Wilson			Maiden Surnam	e)			
ary	of Hand 2 should of Health and M f item 27 is man r other traumat	1	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Nur						
			Daniel Hanke (Husband)  20a. Method of Disposition		Northrid	ge Dr. E				
mor			1 Burial 2 A Cremation 3 Removal from State	cemetery, crer	rnatory or other place rematory rematory		Date 3/2012		- City or Town, State  Ore, Maryland	
Baltimore,	Department Important: I any injury o		21. Signature of Funeral Service Licensee	22	2. Name and Addres	s of Facility			aryland 21221	
	ysician/ Medical	8 11	23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a conse	ath. Do not ent	er the mode of dying	g, such as cardiad	or respiratory a	rest,	Approximate Interval Between Onset and Death	
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rted	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	quence ot):	0 1	Cance	r			
be executed	sician an e burial-tr		resulting in death) Last  Due to (or as a conse	quence of):						
certificate be	ing phy e as the	/Med	IF FEMALE:					1		
<b>Sox</b>	e atte	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of preg 1 Live Birth 2 Fe	etal death 3	Ectopic pregnanc Other (specify)	У			ate of delivery onth Day Year	
S, P.O. I	signed by	by	Part II. Other significant conditions contributing to death but not r	esulting in the u	underlying cause giv	en in Part I.			tribute to the cause of death?	
Division of Vital Records, tal or Attending Physician: The law requires	as 2 S	Completed					24a. Was auto perfi	psy ormed?	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No	
tal F	ector, p	Be	25. Was case referred to medical examiner? Hospital:		Loui	ace of Death (Che		2 L NO	1 165 2 14710	
OT VI	er this c	e: To	27. Manner of Death 28a. Date of injury	28b. Time o	f 28c. Injury	4 ∐ Nursing I ⁄at		dence 6 Oth		
lon	leath. tor: Aft the fur	Certificate:	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be	injury		Yes 2 No				
DIVIS talor Al	rs after or all Directed in by		4 Homicide determined 28e. Place of Injury - At building, etc. (Spec	home, farm, str ify)	eet, factory, office		28f. Location ( City or To		per or Rural Route Number,	
he Hospi	within 24 hours after death.  To the Funeral Director: After this certificate is completely filled in by the funeral director, page	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my kno only one) 3 Certifying Nurse Practitioner: To the best of	ion and/or inves	stigation, in my opinio	on, death occurred	at the time, date	and place, and du	ue to the cause(s) and manner stated.	
Jo to	with To t		29b. Signature and title of certifier		29c. License		0	29d. Pate signe	ed (Month, Day, Year)	
	le		30. Name and address of person who completed cause of death (Ite Dr. Sharon Chung 9000 F		Print)		Balt	more. V	MD 21237	
	Sta Registra		31. Date filed (Month, Day, Year)  AUG 1 4 2012	nature face	0					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:00 P M 2012 William Grant Hendren August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery 6008 Onondaga Rd. If Under 1 Year If Under Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Min. 1**X** M 2 □ F Months Days Hours North Carolina 74 239-52-2689 Aug. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Bethesda 1 Tes 2 No Montgomery 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? 20816 United States 6008 Onondaga Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 XMarried If Yes, Give Year or Dates. VietNam 1 ☐ Yes 2XXX No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Health Insurance Broker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hendren Vera Mae Holloman Russel Blaine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6008 Onondaga Rd., Bethesda, MD Lelia Hendren / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 08/13/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licer Signatur M.00382 Rapp Funeral and Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 20910 933 Gist Ave., Silver Spring, MD Onset and Death Immediate Cause (Final ATHEROSCLEROSIS disease or condition resulting in death) Due to (or as a consequence of) CARDIOVASCULAR DISEASE Due to (or as a consequence of, Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Dav Year Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown

Providen/ Medical Examiner

Physician/

Medical

10a. State

**Examiner** 

**Funeral** 

Director

ms 23a or 28a-f show must be notified at

"natural", or items

permit. Page Department of Important: If any injury or

Directo

Funeral

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Completed

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Physician/Medical

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Certificate:

Medical

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To the Fune

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran-Hospital or Attending Physician; The law requires that the death certificate be been signed by the should be detached cate has I page 2 s this certificate funeral director, 24 hours after death. Funeral Director: After by the

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed? 1 ☐ Yes 2X No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 🗌 Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛣 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Day, Year)

20815

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State

the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LILA T. MCCONNELL, M.D., 5530 WISCONSIN AVE. #1400, CHEVY CHASE, MD 31. Date filed (Month, Day, Year)

only one 29b. Signature

32. Registrar's Signature

4

B. Sparke

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 Physician/ KEVIN, HENRY 2336 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs Months | Davs | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 219-68-7149 1 X M 2 □ F Director 53 Aug. 24, 1958 Maryland Usual Residence of Dec 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location at Director 10d. Inside City Limits marked other than "natural", or items 23a or 28a-f si martic event, the Medical Examiner must be notified 1x Yes 2 ☐ No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 2905 Enterprise Rd 20721 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married þ 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. 1976 traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Truck Driver Be Trancis L. Henry Sr. 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mildred Brandford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Henry/Sister 2905 Enterprise Rd Bowie, MD 20721 or other 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o Maryland Veterans Cem 08-16-2012 | Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. Jenkins Funeral Home, Inc. 21. Signature of Joneral Service Licensee 7474 Landover Rd Hyattsville, MD 20785 Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faurre. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final INTRACRANIAL HEMORRHAGE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence on) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day 2 No 1 ☐ Yes 2 ☐ g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown page 2 should END STAGE RENAL DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No 1 Tes Yes within 24 hours after death.

To the Funeral Director; After this certifical completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

State

Registrar DHMH 17 Rev 06-2011

Medical

29a. Certifier (Check

29b. Signature and title of certifier

31. Date filed (MoAth, Co.)

NUSRAJ-\_SIDDLQUE

iddens 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

SOUTH

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1447526298

GREENE STREET BALTIMORE MD 21215

29d. Date signed (Month, Day, Year)

2012

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08

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20**1**2 Mabel Alice Hughes 1:35 A M August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Edenwald Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 13, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours Min 89 Director 192-16-7312 May Pennsylvania Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traunatic event, the Medical Examiner must be notified at any injury or other traunatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Baltimore MD. Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #826 800A Southerly Rd. 21286 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specity: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Saleswoman Bakerv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 John Α. Roskow Mabel A. Chambers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James P. Hughes/ Son 8023 Forest Drive N.E. Seattle, WA. 98115 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify <u>Owings Mills, MD</u> 21. Signature of F 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, 23a. Part 1. Enter the disease, or combifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months
1 Yes 2 No Pregnant at time of death P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Records, 2 Ho 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 3 No 2 🗆 No 1 Yes ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check examiner? 1 🗌 Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. I Director: After tl 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying, Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ Marshall L. Hollie 11;50PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore Towson Birthplace (State or Foreign Country) . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Months Days Hours 216-54-6414 1 **3** M 2 □ F Director 12/23/1950 MD 61 Yrs 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Medical Examiner must be notified at Director Baltimore MD N/A 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ items 23a 644 E. 36th Street 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 5 1 Never Married 2 Married ≥ Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: If Yes, Give Year or Dates Black "natural", 3 Uidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Hollie Mary Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Campbell-Sister 2516 E. Oliver St. Baltimore, MD 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/28/2012 Randallstown, King Memorial Pk. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H- East 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final of spinal cord injury weeks Physician/ Complicasions disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Fall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 After this certificate has been signed by the attending funeral director, page 2 should be detached for use as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an autopsy performed? prior to completion of cause of death? 1 Yes 2 No 24 hours after death.

Funeral Director: After this certifica etely filled in by the funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Was pice 2 🗆 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No FALL MAY 13 2012 UNC Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) MILTON AVE AND CHASE ST, MITTE Street Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fil 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO MO AARON CHARLES 6701 N.

State Registrar 32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please  1 _ For	State of Mary	land / D	epartmer	t of Heal	th and I	211		egible.	
Physicia	n/	1. Decedent's Name (First, Middle, Las	Hudso.		Certificat	e of Dear	th	2. Date of Dea	Day	2 Year 2	3. Time of Death 12 05 PM
Medic Examin		4a. Facility Name (if not institution, give	street and number)			Town, or Local			4c. Co	unty of Death	-
Funeral Director		5. Social Security Number 6. Social Security Number 1 6. S		rs. last birtho		110	nder 24 Hrs.	8. Date of Birt (Month, Day 09-22-	h		olace (State or Foreign try)
Maryland 28a-f show otified at	rector	Usual Residence of Decedent           10a. State         10b. County           MD         NA	1.0	City, Town o						1	0d. Inside City Limits
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urs after deal ural", or iter I Examiner I	þ	11. Marital Status  1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	n U.S.	13. Was Deced If Yes, spec	cify Cuban, Me	c Origin? (Sp xican, Puerto ecify:	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: Amer	etc. African
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12) 12th Grade		(0	Decedent's Usur Give kind of wo fe. DO NOT use Home M	rk done during e retired)	most of work	king		of Business Ind	dustry
ild be filed v Mental Hyg larked othe atic event,	To Be	17. Father's Name (First, Middle, Last)  James A•	Hudson				Mother's Nam Irene	ne (First, Middle, E.	Maiden Sum Cu	name) Inningh	am
and 2 shou Health and em 27 is m ther traum		19a. Informant's Name/Relationship (T) Kenyetta Moody-I	aughter	30	24 Keny	on Aver	umber or Rur nue Ba	al Route Number	, Mary	land 2	1213
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permi Depai Impoi any ir		21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or comp	Lungs	death. Do no						Maryl	.A. and 21217
Physician/ Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.  Due to (or as a con	Le sequence of	Acal	à M	40 Ca	rdial.	Into	cercli	Interval Between Onset and Death
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s be executed sician and burial-transit	cal Examiner	Cause (Disease or iinjury that initlated events resulting in death) Last	C. Due to (or as a con	sequence of)	:						
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the death c by the atten ached for u	Physician/Medi	in the past 12 menths?  1  Yes  No 9 Unknown	1 Live Birth 2 4 Pregnant at time 9 Unknown		3  Ectopic   5  Other (sp				230	Month	Day Year
quires that en signed k ould be det	by	Part II. Other significant conditions of	ontributing to death but no	t resulting in	the underlying	cause given in I	Part I.				e cause of death? pably 4 Unknown
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Completed							24a. Was a autop perfo 1  Yes	med?	prior to co	osy findings available impletion of cause of 2 No
ysician s certif directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	□ ER/Outr	patient 3 🗆 D	Other:	Death (Chec	k only one) ome 5 ☐ Resid	ence 6 $\square$	Other /Specify	)
ading Ph ath. r: After thi ne funeral	Certificate: 7	27. Manner Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Yea	28b. Tir	ne of 2	8c. Injury at work? 1  Yes		28d. Describe h			
ital or Atte urs after de ral Directo		3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (Sp	ecify)				28f. Location (S City or Tow	n, State)		
the Hosp hin 24 hor the Fune mpleted fi	Medical		sician: To the best of my kiner: On the basis of examinate Practioner: To the best of								
To with		29b. Signature and title of certifier	5 am	-	290	D306	541		29d. Date si	gned (Month, l	20/2
14		29b. Signature and title of certifier  30. Name and address of person who of the control of the	completed cause of death (	1tem 23a) (Ty	ios B	ack Per	u no	ck Noc.	1 8	ecen 1	nayin lez,
Stat Registra	ie ar	AUG 1 4 2012	32. Hegistrar's Si	grature	arks.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 112 Ray Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Baltimore Good Samaritan Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03-23-45 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Country) Director 413-78-1399 MO 1 X M 2 D F 67 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director NA Baltimore 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 4305 Marble Hall Road Apt.#119 21218 items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian Armed Forces?

1XX Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. African ŏ þ 1 Never Married 2 Married 21215-0036 1 Yes 2XX No Specify: Specify: American "natural" 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, United States Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Postal Carrier Services Postal 12th Grade and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1027 W. Lexington Street Baltimore, Maryland 21223 19a. Informant's Name/Relationship (Type, Print) Keisha Hurst-Daughter Department of Health Important: If item 27 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 08-20-12 Owings Mills, MD Garrison Forest 4 Donation 5 Other (Specify) any inj Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Arr disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or es é consocuence of) cause. Enter Underlying Cause (Disease or injury that initiated events executed burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy signed by the atter d be detached for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an p.ge2s autopsy 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year M5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D

DHMH 17 Rev 06-2011

Registrar

ed (Month, Day, Year) AUG 1 4 2012

32. Registrar's gnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Augu :49 P M Evelyn Hayden 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BACTIMARE WASHINGTON ANNE MEDICAL CENT BURNIE KN If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Min 175-38-2567 Director 1 □ M 2 🗓 F Dec. 24 1937 PA Usual Residence of Deceden en "netural", or items 23e or 28a-f show Medical Examiner must be notified at Pege 1 and 2 should be filed within 72 hours efter death with the Maryland ment of Health and Mentel Hygiene.
ent: If Item 27 is merked other then "netural", or items 23e or 28a-f shoury or other treumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 154 Dunlap Road 21122 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Specify 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Hayden, (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Rite Aid 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Hebden Elizabeth Schafer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angletta S. Hayden (daughter) 154 Dunlap Road, Pasadena, MD 21122 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. Date 20c. Location - City or Town, State Aug. 2012 13 1 ☐ Burial 2X Cremation 3 ☐ Removal from State importent: M eny injury or once, Baltimore, MAryland 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Oc 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the dis e, or complications that c death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure ist only one cause on e Immediate Cause (Final Physician/ disease or condition resulting in death) rtat u meta Medical Due to (or as a consequence of): Examiner obstru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospitel or Attending Physician: The law requires that the deeth certificete be executed ettending physicien end for use es the burlei-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 5 Other (specify) this certificete has been signed by the arral director, page 2 should be deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? र्व 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a Was an autopsy 2 No Yes 2 N N 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours efter death.

To the Funerel Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 only one) 3 MC Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Dav. Year) K10752 son who completed cause of death (Item 23a) (Type, Print) Kim 301 Hospital Dr. GKnBurnie MD 21061 6 V 31. Date filed (Month, Day, Year) State **AUG 1 4** 2012 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		State Registrar			Cer	tificate of L	Death		Reg. No	201	2	25802
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Examin	er	723 N. Rosedale				Baltin			40.	. County of De	atri	
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nd 2 s ealth m 27 i		Lynn F. Wilson	- niece		672	24 Paulir	ne Ct; Br	yans Ro	ad,	MD 206	16	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1  Burial 2  Cremation 3	☐ Removal from State			ition (Name of atory or other plac	ce)	Date	20c. Lo	ocation - City	or Town	, State
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Medical		disease or condition resulting in death)	a. Due to (or as	a conseque	ence of):	VICEY					+	
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or Attending Physician: The law requires that the death certificate be after death.  Director: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu	Certificate:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e Place of Ini	ury - At hor	ne, farm, stre		ies Z 🗆 No	28f. Location (	Street and	d Number or F	Rural Ro	ute Number.
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To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying PI	nysician: To the best of	my knowle	edge, death o	ccurred at the time	e, date and place, a	nd due to the c	ause(s) a	nd manner as	stated.	(c) and manner stated
the H thin 24 the F	Me	only one) 3 Certifying N				death occurred at t	the time, date and pla		the cause	e(s) and manner	r as stat	ed.
<b>6</b> ≥ <b>6</b> ⊗		29b. Signature and title of certifier	/	8		29c. Licenso						
•		30. Name and address of person wh	o completed cause of	leath (Item	23a) (Tune D		2118		0	6-4		16
		KASHI P	ATEL		3102	WYN	MAN	PARK	- D	RIVE		21211
Stat		31. Date filed (Month, Day, Year)	32 Registr	ar's Signati	1 6	Red				- 1		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Hamilton 2012 12, 10:03 AM Franklin <u> August</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 79 Director 215-30-1297 1**X** M 2 □ F Maryland July 22, 1933 Usual Residence of Dec 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland rector Dundalk 1 🗆 Yes 2 🖾 No Maryland Baltimore ā 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? USA 21222 Funeral 2408 Meadow Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Automotive Mechanic 8 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie Lucille Hodges ည ğ Joel P. Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2408 Meadow Road, Dundalk, Maryland permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Lorraine Hamilton wife 21222 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition August 15, 1 Burial 2 Cremation 3 Removal from State Dundalk, Maryland Sacred Heart of Jesus Cem. 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License <sup>2</sup>Connelly funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1. Enter the disea Interval Between shock, or heart failure. Listonly Onset and Death Immediate Cause (Final disease or condition resulting in death) ZEWAL Physician FAILVRE 01412 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the at Id be detached fo Yes 2 □ No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ment 1 🗌 Yes 3 Probably 4 Unknown Records, il or Attending Physician: The law require after death.

Director: After this certificate has been sid in by the funeral director. page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Division of Vital B 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖸 No HOSPKE ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours aft To the Funeral Dis completely filled in Hospital ( Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D4636

State

12v

Registrar AUG 1 4 201

DHMH 17 Rev 06-2011

30. Name and address of person who

31. Date filed (Month, Day, Year)

32. Registrar's Signature

**ORIGINAL** 

cause of death (Item 23a) (Type, Print)

Rommo

Complet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201<sup>Year</sup> O Day Physician/ Month 08 10:16 AM Lois Sloan Holmes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 86 233-38-5392 **Director** 1 M 2 XF WV 03/18/1926 Usual Residence of Dece 28a-f show 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 Yes 2 X No Harford MD Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21085 22 Kilgore Ct. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Fitem 27 is marked or Mary Mooney Sloan William Homer Sloan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2365 Woodsfield Lane, Marietta, GA Rick Holmes - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 Department of Important: If it any injury or o cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 08/08/2012 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory Schimunek Funeral Home, Signature of Funeral Se Mce Lice 22. Name and Address of Facility 610 W. MacPhail Rd., Bel Air, MD 21014 Part 1. Enter the disease, or complications that cal shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line Ø Onset and Death Immediate Cause (Final Ventricula Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical attending pł I for use as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ate has been signed by the atter page 2 should be detached for i in the past 12 months? Day Year Month Pregnant at time of death Unknown 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No After this certificate funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 1 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Director: 54 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 0074214 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 Atwood Rd Ste206, Bel AIr. MD, 21014 WKOOr 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 2012 03 Albert Charles Haeger, Jr. 1:45 A M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 2127 White House Road Bel Air If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country) Director 129-20-7372 1 🔀 M 2 🗆 F 85 Yrs NY 04/21/1927 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 🗌 Yes 2 😾 No Harford Bel Air MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be Funeral 21015 2127 White House Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian 11. Marital Status an "natural", or ite Medical Examiner Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'ury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Custom House Broker Freight Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Catherine Hennigan Albert Charles Haeger, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2127 White House Road, Bel Air, MD Richard Haeger - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/11/2012 Glen Burnie, MD Atlantic Crematory 4 Doration 5 Other (Specify) 21. Signati of Funera/Servi 22. Name and Address of Facility Schimunek Funeral Home, Licensee 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pancreatic Cancer Medical Due to (or as a consequence of) **Examiner** 10 Mos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) as the burial-transit law requires that the death certificate be executed Cause Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Year Day 5 Other (specify) Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 ☐ Yes 2 🔀 No Yes 2 🗓 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 [X No ျ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Certificate: 1 X Natural 5 Pending n 24 hours after death.

e Funeral Director: Af 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I comple 29b. Signature and title of co 29c. License number D66912 8-3-2012

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Registrar

DHMH 17 Rev 06-2011

Venkata Parsa, MD, 510 Upper Chesapeake Drive, Bel Air, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 1 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 05<sup>Day</sup> 2012 FOSTER HARRIS 12:50p M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death N/A Gilchrist Hospice Baltimore 5. Social Security Number 214-56-5748 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Days Hours **Director** 1 XM 2 | F 11/22/1951 60 Virginia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 TyrYes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. Biddle St. 21202 1027 E. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highe st grade completed) 11th Grade College (1-4 or 5+) Cab Driver N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Claude Harris Mattie Yancy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Linda Harris Brady(sister) 700 E. Biddle St., Baltimore, MD 21202 Baltimoré, 20b. Place of Disposition (Name of cemetery, crematory or other place) UNK Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔯 Cremation 3 ☐ Removal from State ∂n-site Crematory Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundam Service I Forephadass Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest effects, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ .UNG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease Unique) Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death signed by the at id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, pag Yes 2 N 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The

ABBAS

31. Date filed (Month, Day,

Registrar

DHMH 17 Rev 06-2011

32. Registrar Signatus

6701 N Charles Street Stule 4105

Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 2 Year 2 MONTRELL JOHNSON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WD HOSPITO Baltimore Agnes Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Age (In yrs last birthday 9. Birthplace (State or Foreign Country) MD **Funeral** (Month, Day, Ye Director ugusT Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BAlto 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 u.S.A Prive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Yes 2 No 1 

M Never Married 2 ☐ Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BIACK Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname) ၉ JOHNSON I ATTBUG 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARDNEN-MOTHER ovetta 2815 SUNSET BALLO MD. 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) BALLIMORE, MID 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Michael Ziglier Fun Suc, RA:
Michael Ziglier Fun Suc, RA:
BAI+C, MD 21229 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due tras a consequence of): Examiner Arteriosus Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Prema been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury treme that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Distress 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an emia autopsy certificate has Thromboo topen 1 ☐ Yes 2 🗷 No Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes 2 No Other: ၉ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes funeral 28b. Time of 28d. Describe how injury occurred Certificate: After iniury 1 Natural 5 Pending 2  $\square$  No ☐ Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) cal t 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 60780 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 caton Aue Himore tospita Carolyn Molonev m.D. 31. Date filed (Month, Day, Year, am Registrar's Signature State **AUG 1 4** Registrar

ORIGINAL

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X DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOI	partment of Health and Mertificate of Death	, 0	ene g. No. 2012	25808
i	Physicia Medic		1. Decedent's Name (First, Middle, Last)  ROMONA JOHNSO	N	2. Date of Death	Day 2012 <sup>ear</sup>	3. Time of Death 11:45 A M
	Examir		4a. Facility Name (if not institution, give street and number) FT. WASHINGTON NURSING HOME	4b. City, Town, or Location of Death FORT WASHINGTON		4c. County of Death PRINCE GE	
-	Funeral Director		5. Social Security Number 579-54-7736  Usual Residence of Decedent  6. Sex 1 \( \times \) M 2 \( \times \) F  7. Age (In yrs. last birthday.  7. Age (In yrs. last birthday.)  7. Age (In yrs. last birthday.)	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, You MAY 13	'ear) Cou	nplace (State or Foreign ntry) HINGTON, DC
	aryland a-f show fied at	Director	10a. State 10b. County 10c. City, Town or L  MD PRINCE GEOEGE S FT. WASH				10d. Inside City Limits
	vith the Mi 23a or 28 st be noti	ral Dire	10e. Street and Number 12108 CLEAR CREEK DRIVE	10f. Zip Code 20744	10	g. Citizen of What Cou USA	
36	s after death w al", or items	d by Funeral		Was Decedent of Hispanic Origin? (Spull Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: BL	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. If heath and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv.  Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation a kind of work done during most of work DO NOT use retired) BUSINESS OWNER	ing 10	6b. Kind of Business/li	ndustry
Maryland 2		To Be	17. Father's Name (First, Middle, Last) FRANK LEE DAVIS	iden Surname) NN			
			GWENDOLYN WILSON/SISTER 121	ling Address (Street and Number or Run 08 CLEAR CREEK DRI	VE FT. W	ASHINGTON,	MARYLAND
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot		4 □ Donation 5 □ Other (Specify) RESURRE	ematory or other place) CCTION CEMETERY 8/1	0/12 C	Oc. Location - City or T  LINTON, MAR  TNS FIINERA	
Ä	Imp any	9)	23a. Part 1. Enter the disease, or complications that caused the death. Do not en	7474 LANDOVER ROAL	) HYATTSV	ILLE,MARYL	
	Medical Examiner		shock, or team failure Ust only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  METASTATIC CANCE Due to (or as a consequence of):	R			Interval Between Onset and Death
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Records,	<b>sician:</b> The law requ certificate has beer lirector, page 2 shou	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
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Divisi	ital or Attenurs after deatral Director:		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in the total or	Medical	cause(s) and manner as	ause(s) and manner stated. stated.			
	¥ \$ \$ 8		29b. Signature and title of certifier	29c. License number D42955	290	d. Date signed (Month, August 6	, 2012
	4		30. Name and address of person who completed dause of death (Item 23a) (Type,  EDGER VERDAN POTTER MD 12017 FORT  31. Date filed (Month, Qay, Year) 32. Senistrar's Signature	WASHINGTON ROAD I	FORT WASH	INGTON, MAR	YLAND 20744
	Sta <sup>.</sup> Registra	ar	31. Date filed (Month Day Year) 32 Registrar's Signatur AUG 1 4 2012	arke			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physici edical Exam			me of Death 610 hrs										
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S.A.		3401 Harford Road Baltimore											
Funeral Director			e (State or Virginia										
any		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10d.	Inside City Limits										
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Baltimore, MD 21215-003 pemit Pages I and 2 should be filed within pepartment of Heatin and Mental Hygiene. Important: If item 27 is marked other trinjury or other traumatic event, the Med		21. Strature of Funeral Service Lice see the de, Director Gary P. March Funeral Homeomy, Foord Hill 655 W. Baltimore St; Baltimore, MD 212	lton Pass										
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Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  28f. Location (Street and Number or Rural Rough or Town, State)	ute Number, City										
To the Hospital within 24 hours To the Funeral	Medical (		e(s)										
F × F 3	ž		y, Year)										
		30. Name and address of person who-completed cause of seath (Item 23a)											
		Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											
St Regis	ate	The A. A. P. D. C. B. C.											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Eva Jen Kins 3: 43 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3936 Reisterstown Rd. N/A Baltimore Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 242-58-9529 Director 79 10/24/1932 N. Carolina Usual Residence of Decedent ahow ir than "naturai", or items 23a or 28a-f aho 10a, State 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3936 Reisterstown Rd. 21215 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 X No Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black Completed 3 Nidowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should ba filed within 72 ment of Health and Mental Hyglene. ant: If Itam 27 is marked othar than 7En Grade (0-12) College (1-4 or 5+) Housewife self other traumatic avent, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alberta Moore William J. Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Greencrest Rd., Baltimore, MD 21206 Alvania Scott(daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/13/12 Arbutus Cemetery Baltimore, MD 21. Signature of Funeral Service Licensee Home Tree Brown Jr. Funeral Home retuch 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ rappist rembotic thent disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner andionscular Disease neros lenonic Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and complately filled in by the funeral director, page 2 should be detached for use as the burlan-transit that initiated events Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ASTYLANDAMI 29d. Date signed (Month, Day, Year) D0057465 15 gm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ralphone MD Z1209

Registrar DHMH 17 Rev 06-2011

State

NSkajapa (Sem)

31. Date filed (Month, Day, Year) **AUG 1** 4 2012

2835

32. Registrar's Signatur

Charles Johnson

12-05664

Please Type or Print in Black Indsible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 30, 2012 Year 0557 hrs Charles G. Johnson Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore University Hospital N/A 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Months Days Hours Min. Director Country) unk 1X M 2 F 49 Yrs 10/08/1961 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 No 23a or 28a-f show notified at once. MD Baltimore death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1914 North Ave. 21217 U.S.A. uneral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married 2 X No Yes Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene.
Tennortant: If item 27 is marked other than "matural", or Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: δ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11th Grade Catering self Employed 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leroy Johnson Emma Basilio 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2703 Strongs Ct., Donald Basilio(Brother) Crofton, MDt: If item? 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 8-7-12 on-site Creamtory Baltimore, MD 4 Donation 5 Other Specify 1. Signal re of Funeral Service Licensee <sup>2</sup>ට්ර්පීම්ච්ර්ෆ්ස් ිව්ම්wn Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart the disease, or com Approximate Interval **Physician** at only one cause on each line Between Onset and failure l /Medical Death Immediate Cause (Final disease a Blunt Force Injuries Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED the attending physician ned for use as the burial -Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate by IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Dav Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown certificate has been signed by the sctor, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? ✓ Yes 2 No death? page 1 V Yes 2 No 26.Place of Death (Check only one) director, 25. Was case referred to medical Be Other: Nursing Home 5 Residence 6 Other: this 1 🗸 Yes After 28b. Time of Injury 28c, Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Certification Subject assaulted Unknown Unknown Natural Pending 1 Yes 2 ✔ No I Director: within 24 hours after death.

To the Funeral Director: Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) 1800 blk W. North Ave., Baltimore, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 [ CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b: Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E July 30, 2012 30. Name and address of person who complete cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. Assistant Medical Examiner

31. Date filed (Month, Day, Year)

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2012 LaHatte, Jr. Month Day 01iver Charles 08 10 12:00 p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Middle River Examiner 4c. County of Death 1348 Burke Road Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) March 2, 1955 9. Birthplace (State or Foreign Funeral 1 ★ M 2 □ F Days Hours Min. Months 215-50-5455 Maryland 57 Yrs **Director** Usual Residence of Decedent 28a-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director Middle River Baltimore Maryland 1 Yes 2 X No 9 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 23a Funeral 21220 USA 1348 Burke Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married "natural", or Yes 2 K No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣ No Specify: If Yes, Give Year or Dates white Completed 3 Widowed 4 Divorced Specify: the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 | and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Fire Fighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important. If item 27 is marked any injury or net-ပ Patricia A. Chenowith Charles Oliver LaHatte, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Middle River MD 21220 19a. Informant's Name/Relationship (Type, Print) Charles Oliver LaHatte, Sr.Father 612 Oakdean Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Hilltop Service Corp 8/15/12 1 Burial 2 Cremation 3 Removal from State Towson MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Leonard J. Ruck, Inc. <u>5305 Harford Road, Bal</u>timore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final yocaenia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 10 42 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury Examine Due to (or as a consequence of) physician and the burial-transit death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending philographics at the second IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the P.O. signed by Part II. <mark>Other significant conditions</mark> contributing to dea<u>th b</u>ut not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha irector, page 2 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? **Division of Vital** director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Besidence 6 Other (Specify) 2 ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 atural injury 5 Pending within 24 hours after death. To the Funeral Director: Af completed filled in by the fu 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tit 29d. Date signed (Month, Day, Year) 2012 ho completed cause of death (Item 23a) (Type, Print) 120 8109 HARTORD Rd, WIFF PERKULL MD

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's fignatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Augus 5:20 AM Sharon Gail Lobo 2012 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sina Hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 218-60-3542 Country) Director 1 □ M 2 🗓 F 60 29 52 06 MD ortant: If item 27 is marked other then "netural", or items 23e or 28a-f show injury or other treumatic event, the Medical Examiner must be notified at 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Directo Baltimore Randallstown 1 ☐ Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 9905 Marriottsville Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black 3 Divorced 4 X Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pege 1 end 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: If Item 27 is marked other then eny Injury or other treumatic access. Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade 2yrs Teacher Day Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Willoughby Louis Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shamara Lobo-Daughter 3414 Oak Trail Ct, Tampa, FL 33614 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Memorial \$/15/2012 Arbutus, 21. Signature of Fuseral Service Licens March For Horse 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cardionyopathy 12 years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of sician and burial-transit or Attending Physicien: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 5 Other (specify) Month Dav Year 9 Unknown Part II. **Other significant conditio**ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Diabetes Mellitus Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No after death.

Director: After this certification by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE ၉ 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospitel or A within 24 hours after To the Funerel Directornolletely filled in b Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) folit Da 18246 August-10,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROHIT JAIN, MBBS, since hospital of Baltimore, 2401 W. Belvedere Ave, Baltimore MD 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

SHARON

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Awust 1:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Care System Poin T reiru Ceci Yealth Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Septh, Day Year) 1935 Onto Months Hours 276-30-6590 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Aberdeen Maryland Harford 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 USA 69 Apg Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? 2 NJ 952-Black White etc permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or any injury or other traumatic event than "natural", or ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: white 1970 3XWidowed 4 ☐ Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Military Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Grafe Margaret Earl N. Lipscomb, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Jacqueline Black (sister)</u> 1278 Kirk St., Maumee, Ohio 43537 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 8/11/12 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Owings Mill, Maryland 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Acensee Maryland 21001 Aberdeen, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ nknown disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death i signed by the at id be detached fo 9 Unknown 1 ☐ Yes ∠ ∟ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 🗌 Yes 2 XNo ၉ 1 KInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

4

DHMH 17 Rev 7/2009

m 23a) (Type, Print)

VA Maryland Health Core System, PerryPoint, Maryland 21902

ho completed cause of death (Ite

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13, 2012 Year Margaret Helen Lato 6:15 AM August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Timonium Stella Maris Hospice Baltimore Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 220-22-6893 Director 1 □ M 2 🗗 F Maryland Aug. 7, 1928 85 10c. City, Town or Location rai", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Abingdon Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 USA 127 St. Marys Church Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 end 2 should be flit Department of Health and Mental I Important: If Item 27 is marked c any injury or other treumatic eve once. ည Mary (nmn) Presinger Oliver Franklin French 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 St. Marys Church Road, Abingdon, MD 21009 19a. Informant's Name/Relationship (Type, Print) Michael J. Lato Sr./ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗋 Removal from State Aberdeen, Maryland Paul's Luth. Cem 8-17-2012 4 ☐ Donation 5 ☐₄Other (Specify) of Funeral 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on the line. 23a. art 1. Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) LARYNGEAL CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): spital or Attending Physicien: The law requires that the deeth certificate be executed ours after cleath.

erel Director: After this certificate has been signed by the attending physician end initial in by the funeral director, page 2 should be detached for use es the burlai-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death 1 ☐ Yes 2 🛣 No 9 ☐ Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No 2 🗌 No 1 🗌 Yes Division of Vital 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 💢 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 👿 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours at To the Funerel Discompletely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 9 se number 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TRACIE L. MORGAN, CRNP TIMONIUM, MD 21093

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 4 2012

a.m.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 9 Day 2012 Year 10:15pm JOSEPH LEE LAWRENCE JR. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CENTER TOWSON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 217-38-3659 1 X M 2 □ F 3-28-1941 MARYLAND 28e-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Dapartment of Health and Mental Hygiana. Important: If item 27 is marked other than "natural", or items 23a or 28e-f sho any Injury or other treumatic event, the Medical Examinar must be natified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No N/ABALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2605 LIBERTY HEIGHTS 21215 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black. White, etc. 1 ☐ Never Married 2 🛣 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced Specify: BLACK Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) -12-CHIEF INVESTIGATOR STATES ATTORNEY OFFICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည JOSEPH L. LAWRENCE SR. CARRIE LAWRENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARLENE LAWRENCE (WIFE) 2605 LIBERTY HEIGHTS BALTIMORE, MARYLAND 21215 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial Cremation 3 Removal from State GARRISON FOREST VETERANS 8-17-12 OWINGS MILLS, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses JONATHAN D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Solhae Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attanding physician and for usa es tha buriel-trensit Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day signed by tha a d ba datached f g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cata has baan sig 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No To the Hospital or Attanding Physician: within 24 hours after death.

To tha Funeral Director: After this certific complately filled in by tha funeral diractor, 25. Was case referred to medical examiner? Be Division of Vital 26. Place of Death (Check only one) Hospital Other: 2 No ဥ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPECE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier tical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur F8SHOOD X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D . #4105, Baltimore, MD Shaheey 6701 N.C onth, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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			State Registrar	Cer	tificate of De	ath		1. No. 20	2 25811				
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	Funeral		5. Social Security Number 6. Sex 7. Age (In )	yrs. last birthday)	If Under 1 Year II	Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	g. Birl	hplace (State or Foreign				
ii.	Director		579-56-0594 1 XM 2 🗆 F 6	9 Yrs.	Months Days				hington D.C.				
	nd show at	ا <sub>ة</sub> ا	Usual Residence of Decedent  10a. State 10b. County 10c	c. City, Town or Loc	cation				10d. Inside City Limits				
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	a or 2 be no		10e. Street and Number		10f. Zip Code		1 '	g. Citizen of What Co	· ·				
	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Funeral	3203 Queenstown Dr. #303		207			United St	ates				
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Baltimore, Maryland 21215-0036	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service On the Mos.	382 R	Name and Address o	T <sup>Facility</sup> d Cr	emation		20910				
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical Examiner: On the basis of examin	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
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	4		30. Name and address of person by complete cause of death 7000 Carroll Ave Tak	(Item 23a) (Type, P	Park, M	10 200	112						
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	Registr	ar	AUG 1 4 2012 Sentes 8.	parker									

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	4a. Facility Name (if not institution, give street and number) 5577 Whitby Road	4b. City, Town, or Location of Death  Baltimore	4c. County of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		th(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	219-40-6366 1×M 20F 68	Yrs. Months Days Hours Min.	3/1944 Country) MD
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Baltimore, MI  Demit. Pages I and 2 s  Department of Health a  Infortant: If iten 27 injury or other traum:		Disposition (Name of cemetery, or other place)	20c. Location - City or Town, State
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Balti permit. Departn Imports injury	21. Signature of Funeral Service Licensee MO1585	8717 Groom Posture Or	Balto, MD 21286
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory arr	Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Due to (or as a consequence of):	r Disease	Death
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	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last		
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8760 ifficate I	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
In of Vital Records, P.O. Box 68760, sing Physician: The law requires that the death certificate be example: After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial.	Ves 2 No 9 Unknown 2 Unknown 5	Other (Specify)	
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8 to 5 2 1	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invited and manner stated.  29b. Signature and title of certifier		
4.3 ± 8		29c. License number	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	August 11, 2012
2	Carol H. Allan, MD Assistant Medical Examiner 900	W. Baltimore Street, Baltimore, MD 21223	
Sta Registr		1	

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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MD 21215-0036  4 2 should be filed within 72 hours after death with the Maryland 1th and Mental Hygiene. 10 27 is marked other than "matural", or items 23a or 28a-f she numatic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relationship			19b. Mailing	Address (	Street a	and Number	or Rura	al Route Nun	nber, City o	or Town,	State, Z	ip Code)	
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Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from	State	Place of Dispos crematory or oth	ner place)				ate	ł	ation - Ci	•		
Baltimore, permit. Pages 1 an Department of Her Important: If ite		4 Donation 5 Other Spec	cify:	MD	Vetera						1			Maryla	
Ball Permit Depart Impor		21. Signature of Funeral Service Li	Censee Con	MILL	4 .									lome Inc	
Physician	$\dashv$	23a. Part I. Enter the disease or co	omplications that cause	ed the death										nd 20785 Approximate Inte	rval
- /Medical		failure. List only one cause or Immediate Cause (Final disease											- 1	Between Onset a Death	and
Examiner		or condition resulting in death)	Due to (or as a cor		f):										
	ē	Sequentially list conditions, if any, leading to immediate	b	2000100000	·f)·								+	···	
	ii.	cause. Enter Underlying Cause	c.	isequence o	·· ).										
ngs ge unit	Examin	events resulting in death) Last	Due to (or as a cor	isequence o	f):										
be executed sician and nurial - transit	dical	UNPENDED	dAMENDED										$\dashv$		
60, ate be hysicie e burig		IF FEMALE:	23c. If yes, outo	ome of preg	nancy						23d. D	ate of de	livery		_
687 ertifica ding p	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fe	tal death	3	Ectopic pre	egnancy	/		onth	Day	Year	
Box 6876C he death certificate i the attending phys hed for use as the b	Physician/M	1 Yes 2 No 9 Unkno		at time of de	5 Otl	ner (Specify	)				.0				
O. But the d		Part II. Other significant condition	ns contributing to de	ath but not r	esulting in the u	nderlying ca	use giv	en in Part I.		23e. Did to	bacco use	contribu	te to the	cause of death?	,
ires that the signed by the detached	d b									1 Yes	2 🗸 N	lo 3	Probab	ly 4 Unknow	vn
of Vital Records, ng Physician: The law require this certificate has been sinneral director, page 2 should b	ompleted									24a. Was autop				sy findings availa pletion of cause	
Reco The law cate has	E				-					1 Yes	rmed? 2 No	dea 1 ✓	th? Yes	2 No	1
Vital Reconstitutes of the conficute of the certificate of director, page	Se C	25. Was case referred to medical examiner?	7			26.		f Death (Ch							
hysic hysic al dire	P B	1 🗸 Yes 2 No		tient 2	ER/Outpatient					lome 5			Other: S	cene	
ding Ph		27. Manner of Death  1 Natural 5 Pendin	28a. Date of Ir (Month, Day Aug 10, 20		28b. Time of It 0021 hrs	njury 280		at Work? s 2 ✔ No	Isu	d. Describe I I <b>bject driv</b>			icle ro	oll-over collis	ion
Division tal or Attendir rs after death. al Director: A	cati	2 🗸 Accident Investig	gation 28e Place of	Injury - At h	ome, farm, stree	t. factory. of				f. Location (	Street and	Number o	or Rural	Route Number, (	City
Divi	Certification:	3 Suicide 6 Could I determ	not be		d / Highway	, , , , , , , , , , , , , , , , , , , ,		J.		or Town, S irtin L. King	itate)				
Hospi 24 hou Fuoer tely fil		20- 0-4%	sician: To the best of			red at the tin	ne, date	and place,	and du	e to the caus	e(s) and m	nanner as	stated.		7
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	edical	one) 2 Medicai Exami	Iner: On the basis of ex and manner state		nd/or investigat				red at th	e time, date					
	ž	29b. Signature and title of certifier	1 1	SIN	\ .		icense r							, Day Year)	
		Munk	nassell,	1104	1		D.C.M	.E.			Augus	st 10, 2	J IZ		
5		30. Name and address of person w Melissa Brassell MD				. Baltimn	re Str	eet. Balti	more.	MD 2122	23				
St	ate	31. Date filed (Month 14 Pyger)		rar's Signati		_		.,	1						
Regist		AUG 14	LUIL Chie	un,	D. 190	Mas									

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2-05/30	Please Type or Print in Black indelible ink. Ensure A	ili Copies Are Legible.		
Deandre McCullough	State of Maryland / Department of Health and M	lental Hygiene	2012	2582
1- For State	Certificate of Death		2012	2002
Registrar	oo, iin od to o, bodin	Reg. No.		
Playercian/ 1. Decedent	s Name (First, Middle,Last)	2. Date of Death	3. T	ime of Death

		1- For State Registrar	Certific	ate of Death	Reg. N	lo.	2 2002
Physicia		Decedent's Name (First, Middle, Last	000		2. Date of Death Month Da	v Year	3. Time of Death
Medical Exami	1er	4a. Facility Name (if not institution, give	Cullough	4b. City, Town, or Location of Deatl	August 1, 20	4c. County of Death	1824 hrs
		1509 Langford Road	e street and number//	Gwynn Oak		Baltimore Cou	nty
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birt	thday) If Under 1 Year If Under 24Hrs Months Days Hours Mir	_ / ',	M/DD/YYYY) 9. Birth Foreign	
Director		213-90-63/9 10	(M 2□F 35	Yrs.	5/23/1		intry) MD
any		Usual Residence of Decedent  10a. State  10b. County	10c. CityaTown	or Location	/ •	1	10d. Inside City Limits
		MA Rall	• 1 7)	4 4 4 4 4		ľ	1 Yes 2 No
Aaryland 28a-f show 1 at ouce.	흸	10e, Street and Number	more ra	10f. Zip Code	10g (	Citizen of What Coun	
215-0036 be filed within 72 hours after death with the Maryland nnal Hygiene. rked other than "matural", or items 33a or 28a-f sho ent, the Medical Examiner must be notified at once.	Funeral Director	36 Terron	Ct.	21234		USA	,.
h with	era	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S		14. Race - Americ White, etc.	an Indian, Black,
ter deat			1 Yes 2 No	1 Yes 2 ✓ No specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: 1310	cic
urs af	d b	15. Decedent's Education (Specify or	l or Dates: nly highest grade completed) 16a.	Decedent's Usual Occupation (Give kind of		. Kind of Business/Ir	
72 ho	e	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life. DO NOT use ret	ired)	1.1	
5-0036 led within 72 hours a Hygiene. I other than "natura, the Medical Examin	Completed	12th	NA U	hemployed		NA	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	BeC	17. Eather's Name (First, Middle, Last)	Mough	Denis	e (First, Middle, Maid Bov	en Surname)	
Z. = 0 = 5	2	19a. Informant' Name/Relationship (T	ype, Print ) 19	b. Mailing Address (Street and Number or	Rural Route Number,	City or Town, State,	Zip Code)
e, MD I and 2 short Health and item 27 is		Denise Andre	WS-MOTHER S	ble Terron Ct. F	arkvill.	e, MD 2	.1234
nore, MD 2 ages I and 2 shou nt of Health and N t: If item 27 is n other traumatic	- 1	20a. Method of Disposition  1 Burial 2 X Cremation 3		of Disposition (Name of cemetery, cory or other place)	Date 20	c. Location - City or T	rown, State
imC Page ment c	ı	4 Donation 5 Other Specify	- 10n S	ite Crematory 81	3/2012/	Baltimor	e, MD
Baltimore bernit. Pages 1 a Department of Hs Important: If it injury or other t		21. Signature of Funeral Service Licer	see	22. Name and Address of Facility	March-	FIH-Eas	+
Physician	-	23a Part I Enter the disease, or comm	olications that caused the death. Do no	ot enter the mode of dying, such as cardiac	or respiratory arrest	timore, M	Approximate Interval
Medical		failure. List only one cause on ea	ach line.			3	Between Onset and Death
Examiner	- 1	and the second of the second	Heroin Intoxicat:  Due to (or as a consequence of):	lon			
		Sequentially list conditions, b.					
		cause. Enter Underlying Cause	Due to (or as a consequence of):			7	
red nsit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	/Medical	X UNPENDED	AMENDED 23a, 27, 28a-	-f,per me,g930 8-16-	12 sm		
760, ficate be g physic	Ž,	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy			23d. Date of delivery	
68 certific nding se as	ä	past 12 months?	1 Live birth 2 4 Pregnant at time of death	Fetal death 3 Ectopic pregna	ancy	Month Da	ay Year
Box 68 e death certif	Physician	1 Yes 2 No 9 Unknown	1 '	Other (Specify)			
cords, P.O. Box 68 law requires that the death certified has been signed by the attending 2 should be detached for use as		Part II. Other significant conditions	contributing to death but not resulting	g in the underlying cause given in Part I.	1	co use contribute to the	
S, P	d by	-			1 Yes 2	No 3 Proba	ably 4 🗹 Unknown
cords law requ has been	Completed				24a. Was an autopsy		opsy findings available impletion of cause of
lecc The lay	E I				performed 1 Yes 2		2 No
ital Recions The lactoriticate lactor, page	88	25. Was case referred to medical		26 Place of Death (Check	only one)		
Vit hysici this o	ပ	1 Yes 2 No				dence 6 🗸 Other:	Scene
n of ding Ph		27. Manner of Death  1 Natural 5 Deading	(Month, Day,Year)	Time of Injury 28c. Injury at Work?	28d. Describe how i	njury occurred	
SiOr Attend death death sctor:	ij	2 Accident 5 Pending Investigati	011	6:18 pm   1 Yes 2 X No	unknown		
Division of Vital Records, ral or Attending Physician: The law require rs after death.  The law rector: After this certificate has been sided in by the funeral director, page 2 should be in by the funeral director, page 2 should be in by the funeral director.	Certification:	3 Suicide 6 X Could not determine	be	arm, street, factory, office building, etc.	or Town, State)	1509 Langf	Route Number, City
lospit 4 hour 'unera		4 Homicide  29a. Certifier Designing Physical	Tound at	thome ath occurred at the time, date and place, and	due to the cause(s)		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Ondoct only	On the basis of examination and/or in	nvestigation, in my opinion, death occurred a			
To vii	₩.	29b. Signature and title of certifier	and manner stated.	29c. License number	290	d. Date signed (Mont	h, Day.Year)
		Poter : ()	700 11 - 4000	O.C.M.E.	. At	igust 2, 2012	l
W NA		30. Name and address of person who					
ork		Patricia Aronica-Pollak MD		iner 900 W. Baltimore Street, E	Baltimore, MD 2	1223	
Sta Registi	1.7	31. Date filed (Month, Day, Year).	32. Registrar's Signature	Kad			

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ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20

			_ For	State of Ma	aryland /	Depa	artment of H	lealth and	d Mental H	ygiene				
			1 - State Registrar			Cer	rtificate of	Death		Reg. No.	201	2	2582	
			1. Decedent's Name (First, Middle, Las	st)					2. Date of I				3. Time of Death	
	Physicia		Noma Geraldi	ne Marl	att		august					Day Year 7 7012 1:25 A M		
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	r Location, of De	eath of	4c.	County of De	ath		
			VA CLRC L	OCH RAL	IGN		B	rlin	vorl					
	Funeral		5. Social Security Number 6. S		e (In yrs. last		If Under 1 Year Months Days	If Under 24 H		Birth Day, Year)	9. Bi	rthplac	ce (State or Foreign	
	Director		330 07 7231	I M STIFF I (	01	Yrs.	month bays	_ IIOuio III		-1910			Texas	
	pu 🖈 🗆		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation					100	. Inside City Limits	
	aryla shor	7	Maryland Montgo	marv	100. Oity, 10		rmantown					100	1 □Yes 2¥CXNo	
	he M	ect		mer y		061	10f. Zip Code			10- 03	izen of What C			
	a or i	급	10e. Street and Number 18332 Timko Lane				20874					ountry	r f	
	should be filed within 72 hours after death with the Maryland rund Mental Hygiene. I will have a constructed other than "natural", or items 23a or 28a-f show umatic event, the Medical Examination and in a constitution of the Medical Examination of the Medical Exam	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13 \	Was Decedent of H	lispanic Orlgin?	(Specify Yes or I	No-	14. Race - Am	erican	Indian	
	ter d item	ᇤ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 ☐ 1	٧o	1	f Yes, specify Cuba	an, Mexican, Pu	verto Rican, etc.)		Black, Wh			
2	urs al	β	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	WWII	1	I∐Yes 2ŽNo	Specify:			Specify: White			
2-003e	2 hou	Completed	15. Decedent's Ed		10	6a. Deced	dent's Usual Occup	ation		16b. Kind of Business/Industry			stry	
7	hin 7 9.	ple	(Specify only highest gra		i+)	life. L	kind of work done DO NOT use retired	during most of v d)	working					
7	d with	ν	12	College (1-4or 5	,		Nurse				alth Ca	re		
2	al Hy oth vent	Be (	17. Father's Name (First, Middle, Last)						Name (First, Mida					
<u> </u>	uld b Ments Irked Itic e	To	Ira Cook					Pearl	Ellen	Pati	cen			
B	and ls me		19a. Informant's Name/Relationship (				ng Address (Street							
Σ.	and and n 27		Deborah M. Kitchi	in - Daugn			6 Walnutw		ie Germa					
บ	es 1 of H if iter		20a. Method of Disposition 1 XI Burial 2 □ Cremation 3 □	Ramoval from State	20b. Place ceme	e of Dispo etery, cren	sition (Name of natory or other plac	ce)	Date	1	ocation - City o			
allillor	Pag ment ant: ury c	١.,	4 □ Donation 5 □ Other (Specific		Dalla	s-For	rt Worth	Cem; <sub>O8</sub>	-17-2012	Dal.	las, Te	xas	3	
ם מ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maryleal Examination in the Indian Examination once.	21. Signatur 1 uneral Service Ucensee  22. Name and Address of Facility  Leonard J. Ruck, Inc. Baltimore										Rç	ad	
_	0 5 5 0 0		Cay Vay	<del>}</del>							nore, r	1		
			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only	blications that caused one cause on each lin	I the death. D	o not ent	er the mode of dyir	ng, such as card	diac or respiratory	arrest,		l Ir	pproximate nterval Between Inset and Death	
F	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Left	This	h	Sarc	oma						
w'	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	ce of):								
		Jé.	Sequentially list conditions, if any, leading to immediate	b	a consequent	ne of).								
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	240 10 (01 40	a consequent	30 31,1						l		
	execting and and and and and and and and and and	Exal	that initiated events resulting in death) Last	C. Due to (or as	a consequenc	ce of):						$\vdash$		
0/00	icate be executed physician and the burial-transit	dical		. d										
8	tificat g phy as th	edi												
5	w requires that the death certifi been signed by the attending i should be detached for use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			∃Ectopic pregnanc				23d. Date of d	elivery		
٥	deat le attr	icia	in the past 12 months? 1 □ Yes 2 No	4 ☐ Pregnant a			Other (specify)	у		.	Month	D	ay Year	
ָ ב	at the by th tache	Phys	9 ☐ Unknown	3 dikilowii										
ກົ	as tha gned se de	by F	Part II. Other significant conditions of	ontributing to death b	ut not resultin	g in the ur	nderlying cause giv	en in Part I.	23e. Di	d tobacco (			cause of death?	
cords,	equir								_ 1[	Yes 2	□ No 3□	robat	oly 410 Unknown	
ັນ	e law r has be je 2 sh	ple							24a. Wa	as an topsy	24b. Were	autops	y findings available eletion of cause of	
	The ate h page	Completed							pe 1 □ Yes	rformed?	death			
<u> </u>	ctor,	Be (	25. Was case referred to medical examiner?						Death (Check onl	v one)				
5	hysio his o	인	1 Yes 2 No	Hospital:	ent 2 ER/	Outpatien	nt 3 □ DOA Oth	er: 4🗹 Nursin	g Home 5 ☐ Re	sidence	6 □Other (Sp	ecify)		
=	ing P	ü	27, Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 281 <i>y, Year)</i>	b. Time of Injury	Wor	k?	28d. Describ	e how injur	ry occurred			
1200	tend leath. tor; / the fi	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2□No	001 1 11	(0)		· -		
5	or At after of Direc	Certification:	4 ☐ Homicide determined	26e. Place of inj	c. (Specify)	, rarm, stre	eet, factory, office		City or 7	own, State	nd Number or i	iurai F	loute Number,	
	spita nours neral fillec			ysician: To the best										
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Examone)	dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.							o place, and d	ue to th	ne cause(s)	
	Veith To t	Σ	29b. Signature and title of certifier				29c, Licens	-		29d. Da	te signed (Mo	nth, Da		
			1				D5-6.	508		au	greet	_/	, 2012	
	4.7		30. Name and address of person who 3900 LOCH RL	completed cause of d	eath (Item 23	a) (Type,	Print) X/A/	GRONG	> SHI	40		0		
	· IV		3900 LOCH RA	+VEN 13	LVU.	7	sar my	a e	MD	2,	121,	1		

State Registrar

DHMH 17 Rev 1/2001

12-	06019	
12-	.00019	

Douglas Paul Mcguire

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1Ca3C	ype of Fillit in black indelible lik. Elistie All Copies Ale	i
	State of Maryland / Department of Health and Mental Hydiene	

		1- For State Registrar Certific	cate of Death	Reg	. No.	2 2582	
Physicia Medical Exami		Decedent's Name (First, Middle, Last)		2. Date of Death Month D August 11, 2	Day Year	3. Time of Death	
Medical Exami	IIGI	Douglas Paul Mcguire  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	10361115	
		Baltimore Washington Medical Center	Glen Burnie		Anne Arundel		
Funeral Director		5. Social Security Number 212–17–3055 6. Sex 1 7. Age (In yrs. last bi	Months Dave House Min	_	(MM/DD/YYYY) 9. Birth 1986 Foreign Cou		
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location			10d. Inside City Limits	
	<u> </u>	Maryland Anne Arundel	Pasadena			1 Yes 2 No	
eath with the Maryland items 23a or 28a-f show ust be motified at once.	Director	10e. Street and Number 8467 Bussenius Road	10f. Zip Code 21122	10g	. Citizen of What Count		
n with ms 23.	eral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Value of Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? ( Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,	
은 5 원	by Funeral	3 Widowed 4 Divorced If Yes, Give Yaar or Dates:	1 Yes 2 X No specify:		Specify: W	hite	
hours afte "natural",		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	<ul> <li>Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti</li> </ul>		6b. Kind of Business/In	dustry	
D36 thin 72 re. than edical	Completed	10	Sales		Food		
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than 'e event, the Medical		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	· ·		
2121 Ild be f Mental narke	To Be	Peter O. McGuire  19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or F			Zin Coda)	
MD d 2 shouth and 1 is 1	1		8467 Bussenius Road,				
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Medi		1 Burial 2 X Cremation 3 Removal from State Crema	of Disposition (Name of cemetery, atory or other place) TO Crematory Inc. Aug	g. 15	20c. Location - City or T Baltimore,		
Baltin pemit. P Departme Importan injury or		4 Donation 5 Other Specify, 21. Signature of Funeral Stylice Licensee	22. Name and Address of Facility	2012   Stallings	Tunoral E	iomo D A	
		Muschell (Stall 57)	3111 Mountain Ro	ad, Pasac	dena, MD 21		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.		r respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. narcotic (methado Due to (or as a consequence of):	one) Intoxication			Death	
	ē	Sequentially list conditions, if any, leading to immediate  b					
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
760, icate be executed physician and the burial - transit		d.					
D, be exe sician a	Medical		-f,per me,g933 11-16-	-12 sm			
O D D D D D D D D D D D D D D D D D D D							
Box 687  death certific  the attending i	Physician/		5 Other (Specify)		t).	Ì	
O. B. at the de I by the tached f			ng in the underlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?	
ires that the signed by	1 Yes 2 No 3 Probably 4 ✔						
Records, The law requir ficate has been si	Completed			24a. Was an autopsy	prior to co	psy findings available mpletion of cause of	
tal Rec	팅			performe 1 Yes 2	ed? death? No 1 ✓ Yes	2 No	
ician: s certifi irector,	8	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ✓ ER/C	26.Place of Death (Check of Death)  Outpatient 3 DOA Other Nursin		sidence 6 Other:		
ing Phys After this	일	163 2 110	. Time of Injury 28c. Injury at Work?	28d. Describe hov			
ion trendir death. tror: A	aţi	I Natural F	10:00 am 1 Yes 2 X No	unknown			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	Suicide 6 X Could not be determined (Specify) dwe11:	farm, street, factory, office building, etc.	28f. Location (Street or Town, State Pasadena	eet and Number or Rura e)229 Sun G1 1,MD.	Route Number, City	
To the Hospital within 24 hours To the Funeral completely filled	Medical (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or and manner stated.					
F > F 0	ž	29b. Signature and title of certifier	29c. License number	G <sup>m</sup>	9d. Date signed (Mont.	h, Day, Year)	
		Theoder U. King Java	Let A.	F T hou	August 12, 2012		
		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Theodore M. King, Jr., MD. Assistant Medical Exam</li> </ol>	niner 900 W. Baltimore Street, Ba	altimore, MD 2	21223		
		31. Date filed (Month, Day, Year)  32. Register's Signature			· · · · · · · · · · · · · · · · · · ·		
Regist	_	AUG 1 4 2012 Chara A	pull				
DHMH 17 Rev 1/20	001	OF	RÍGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Allen Muse Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours (Month, Day, Year) 218-54-1215 Director 1 M 2 D F 59 10/24/52 PA 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director MD Carroll 1 Yes 2 No Westminster 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 82 1/2 Pennsylvania Avenue 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Ireland Muse Nellie Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emilee Bonds-daughter 1696 Brimfield Cir., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 8/16/12 Evergreen Mem Finksburg, MD 4. □ Donation 5 □ Other (Specify) 21. Sunstant of the neral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home, P.A. 254 E. Main St. Westminster, MD 21157 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final SEPTIC Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day signed by the at I be detached for g . Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown filled in by the funeral director, page 2 should peen ENCEPHALOPATH 24a. Was an 24b. Were autopsy findings available autopsy performed? prior to completion of cause of death? has certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 卢 2 1 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, MD ZOO MEMORIAL AVE, WESTMINSTER, MD FRANCIS KHOO, MD 31. Date filed (Month, Day, Year) AUG 1 4 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 11:00 p M 0 2012 Doris Helen Mazzie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Baltimore Stella Maris If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) Director 220 07 4117 1 □ M 2 🏻 F 91 12/21/1920 MD Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Nottingham MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 U.S.A 6 Juliet Lane #203 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Meat Cutters Union Office Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James L. Rayman Marie M. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR Ode Ct. Nottingham, Md 21236 R. Ernest Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory 8/12/2012 Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md 21236 Pht 1 Enter the disease, or complications that chised shock, or heart failure. List on the cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death END Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. (Disease or injury) Due to (or as a consequence of) eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burlal-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical that the death certificate be IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 month
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 A 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 2300 31. Date filed (Month, Bay, Year) 32. State Registrar

MEUS 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 10 Pay 2012 Pear Physician/ 9:00а м Mildred Viola Murphy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Aberdeen 447 Baltimore Street 8. Date of Birth (Month, Day, Year) May 9, 1921 9. Birthplace (State or Foreign Country) Maryland 1 Year If Under 24 Hrs. If Under Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Days Min. Director 220-07-9993 91 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director a or 28a-f sh be notified a 1 X Yes 2 No Harford Aberdeen Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a USA 21001 447 Baltimore Street 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Never Married 2 Married Completed by Maryland 21215-0036 Specify: Afro-American 1 Yes 2X No Specify: 3 Widowed 4 Divorced marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. cleaners laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ida Tennent Allen Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum Lavinia Watters (niece) 158 Martha Lewis Blvd., Havre de Grace, MD 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Mt. Calvary Cemetery 1 Burial 2 Cremation 3 Removal from State Aberdeen, Maryland 8/18/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tarring—Cargo Funeral Home, P.A. 21. Signature of Funeral Service Acensee Cirstens Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that consed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has be irector, page 2 sl performe 1 ☐ Yes 2 ☐ No 25. Was case referred to predical å 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after deaun.

To the Funeral Director, After this of commieted filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 🗹 Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anne 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 2012 Margaret Alice Marks August 11:30 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Friends Nursing Home Sandy Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min (Month, Day, Year) 096-18-9400 **Director** 1 🗆 M 2 🛛 F 92 August 8, 1920 New York ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Director 1 ☐ Yes 2 🕅 No Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17340 Quaker Lane 20860 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education. 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Registered Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Wood Alice Delahanty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 27 Richard C. Marks / Step-Son 900 West 190th Street., #9C, New York, NY 10040 Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date Montgomery crematory or other place) 1 Durial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August 14, 2012 Bethesda, Maryland Crematorium, Inc. 21. Signature of Fund 13 Vicensee 22. Name and Address of Facility Funeral Home, Bethesda—Chevy Chase, Inc. M01619 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. siri.n Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Foot Ulcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Peripheral Arterial Disease Due to (or as a consequence of): resulting in death) Last physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 X No Day Year Pregnant at time of death the g Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 autopsy performed? 1 Yes 2 X No certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

e Funeral Director: A bletely filled in by the fi ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) To the Hospital Medical 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2, To the F complet 29b. Signature and title of certifier August 13, 2012 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher Mays, M.D. 18111 Prince Philip Drive, Suite 207, Olney, Maryland 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

2012

AUG 14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elsie Frances Neubert August 10 2012 Year 9:00 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) est Virginia 235-40-0959 Days Hours (Month, Day, Year) 10/22/1927 Min. Director 1 □ M 2 🛣 F 84 West ms 23a or 28a-f show must be notified at 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Rosedale 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 2024 Flintshire Road Apt 201 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 27 is marked other than "natural", or iter traumatic event, the Medical Examiner 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 🔯 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cafeteria Worker School System 8 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other 1 any Injury or other traumatic event, III once. Be Maryland 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) ည Aretta Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Baker Daughter 7805 Wilson Avenue Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 08/17/2012 Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. muchael 6009 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition END STAGE RENAL DISEASE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of): use as the burial-transi Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 🗖 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of c 29d. Date signed (Month, Day, Year) 10 5 V who completed cause of death (Item 23a) (Type, Print) JONES, 2300 DULANEY VALLEY RD. **JACKIE** TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 10:52 AM August Jacqueline Louise Norris . Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 410 W. Franklin St. Apt 3B 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min Director 1 M 2 F Usual Residence of Decedent 0 an 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at Director 1 Yes 2 No more 10f. Zip Code 5 Street and Number 10g. Citizen of What Country? 23a Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Marital Status 12 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Hygiene. Elementary/Secondary (0-12) traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last, and Mental Fisher is marked or ည Page 1 and 2 should be Odge MOY 19b. Mailing Address (Street and Number or Rural Rou e Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) it of Health a other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory ō Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Pacility Home Sign 35 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Direcise 2010000 END STAKE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Grownying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 month 1 Yes 2 No Po Month Day Year Pregnant at time of death igned by the at be detached for 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bade 2 s autopsy performed Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Medical Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 5 Pending Accident Investigation the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Registrar

State

29b. Signature and title

AUG 1 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

702

32. Registrar's Signature

29c. License number

D002602F

40th Street

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 13°, 2012 ear 11:45A M NEHRENZ MARGARET JEWELL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore Oak Crest If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 91 **Director** 214-14-4661 1 □ M 2 🗱 🗶 01/09/1921 Maryland 8/13/2013 or 28a-f show 10b. County 10d. Inside City Limits 10c. City. Town or Location Examiner must be notified at Director 1 Yes 2 No Baltimore Baltimore Marvland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a Funeral 21234 USA 8810 Walther Blvd #1009 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Hargarel Nehrenz White Completed ¾ Widowed 4 ☐ Divorced any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) ပ Wilhelmina Theresa Kloes George Britton Ogier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4014 Holly Knoll, Glen Arm, Maryland 21057 19a. Informant's Name/Relationship (Type, Print) DTR Patricia N. Legters 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place

Moreland Memorial Park 1 🗶 X Burial 2 🗌 Cremation 3 🗌 Removal from State 08/17/2012 Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funeral Service Licenses 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be .24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 the attending p for use as F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementio 2 X No Division of Vital Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner?

1 Yes 2 26. Place of Death (Check only one) Be မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29d. Date signed (Month, Day, Year) 29b. Signature and titl 2 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Putuilk MO 21234 froo wa lither andmon Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 13, 2012 Year Physician/ 4:55A DONNA **JEAN** NORFOLK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours (Month, Day, Year) Director 214-56-8758 1 □ M 2 💢 F 05/30/1951 Maryland Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evandral minut by nutflied at once. 10d. Inside City Limits 10b. County 10c. City. Town or Location Directo 1 **X**Yes 2 □ No Maryland None Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3101 Evergreen Avenue 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: 3 Widowed 4 X Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highe during most of working College (1-4 or 5+) Elementary/Secondary (0-12) Security Investigator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Julia Josephine Heyda Edward Harvard Matthai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Arthur Wiedefeld 3101 Evergreen Avenue Baltimore, Maryland 21214 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metro Crematory or other place) 1 Burial 2 XXCremation 3 Removal from State 08/17/2012 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Licen 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any fracing to immediate cause. Enter Underlying Cause (Disease or injury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Day 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerforme performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 6 ☐ Could not be 3 U Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Se Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Certifying Nu 29b. Signature and t 29c. License number 29d. Date signed (Month, Day, Year) 851700 of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ VORRIS august Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** NA 9. Birthplace (State or Foreig Birthpias Country) VA ge (In yrs. last birthday) 8. Date of Birth **Funeral** 227-80-3218 53 1 🗆 M 2 🕱 F Director Usual Residence of Deced 10d. Inside City Limit 10c. City, Town or Location 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County Ħ Director 1 Yes 2 D permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified. Gwynn Oak NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 11 Crestford Court 21207 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Black, White, etc. African 1 Never Married 2 Married 1 Yes 3 21215-0036 1 Yes 2 X No Specify: Specify: American 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Johns Hopkins Hospi 2yrs. Nurses Assistant 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) Hilda Kelly Baltimore, Maryland 17. Father's Name (First, Middle, Last) Norris ပ Herbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3303 Barcroft Drive Springdale, Maryland 20774 Herbert Norris-Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Lancaster, VA. 08-14-12 Family Plot 4 Donation 5 Other (Specify) Wylie Funeral Home P.A. Signature of Funeral Service Licensee Gilmor Street Baltimore, Maryland 2121 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between shock, or heart failure. List only one car Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day in the past 12 months?

1 Yes 2 No g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2**X** No 3 Probably 4 Unknown Completed 24b. Were autopsy findings availal prior to completion of cause death? 24a. Was an autopsy has perfor After this certificate 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA မ Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as tated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 800 Date filed (Month, Day, Year) State Registrar

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	JEROME T.	NAPORA		SON	83	7 MEADOW	RD. S	EVERN	MD 211	44				
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	21. Signature of Funeral Service censes 22. Name and Address of Facility FINK FUNERAL HOME, P.A.													
once.	K. CRECOR FINK M01148 426 CRAIN HWY SW CLEN BURNIE, MD 21061  23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate													
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year PM Odoms 3:52 Henry 2012 05 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of MD Medical Center Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☑M 2 ☐ F **Director** ·f show or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ŏ ms 23a or must be r Funeral permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Never Married 2 Married Yes 2 No ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Yes, Give 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry h and Mental Hygiene.

77 is marked other than "r Elementary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) မှ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetary, crematory or other place 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) o Funeral Service Licensee 21. Signatu 9 Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ptiyeician/ Rectal CANCEL disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy for Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Metastatic prostate Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Enterobacter bacteremia cloacae autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be ( 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Matural injury s after dea. ral Director: Aftr hv the fi 5 Pending 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours af Funeral Di Jetely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2.

To the F
complet 29d. Date signed (Month, Day, Year) Fladodi, 05 2012 1861781809 August

Registrar
DHMH 17 Rev 06-2011

State

Windsor Ln, Bethesda, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4616

32. Registrar's Signature

Cyrus Hadadi;

31. Date filed (Month, Day, Year) AUG 1 4 2012

# Baltimore. Maryland 21215-0036

Box 68760. P.O. Division of Vital Records.

			For State Registrar	State of Ma		d / Depa		lealth and N	Mental Hyg	_	n 1 2	25831
	Physicia	an	Decedent's Name (First, Middle, La	st) REGINA	A KARE	n o'doni	VELL		2. Date of Deat Month	h Day	Year	3. Time of Death 5:00 P M
	/Medic Examin		4a. Facility Name (If not institution, given 1628 Plum Street				4b. City, Town, or Baltimore	Location of Death		4c. County	of Death	3.001
	Funeral Director			Sex 7. Ago I□M 21XIF	58 (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 12	Year) 1954	Coun	ace (State or Foreign try) ryland
	ow T		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				10	Od. Inside City Limits
	ne Mary 28a-fsh	ector	Maryland  10e. Street and Number	N/A			10f. Zip Code	Baltimore	1	0g. Citizen of t	What Count	1 X Yes 2 No
ř	3a or	al Dir		8 Plum Street			Toi. Zip code	21226	'	_	USA	
0000	ges I and 2 should be lied within 72 hours after beath with the marylating of effects and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examina, must be notified.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🍱 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba □ Yes 2 🛣 No	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)		ce - Americ ck, White, e	tc.
ָר ה	'natur	eted	15. Decedent's Education (Specify only highest graduations)	ducation ade completed)		16a. Deced	lent's Usual Occup	ation during most of work	sing	16b. Kind of B	usiness/Ind	lustry
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Mary	alth and h		19a. Informant's Name/Relationship (	(Type. Print) (Friend	i)			a <i>nd Number or Ru</i> Ba <b>ltimore,</b>			State, Zip	Code)
ָבְי עָּ	permit. Pages Fand 23 Department of Health a Important: If item 27 is any injury or other trau		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specia		20b. Pl	lace of Disposemetery, cren	sition (Name of patory or other place	e)n	Date	20c. Location	City or To	wn, State
חשו	Departm Departm Importa any infu once.		21. Stanature of Funeral Service Lice			22	Name and Addre	se of Facility	Sumo	J. BA	T. 10	1/2/3×0/
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	ertifical	Be C	25. Was case referred to medical examiner?						1 □Yes th (Check only on		1 □Yes	2 🗆 140
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5	th. r: After e funer	ation	1 X Natural 5 Pending 2 Accident investigatio	(Month, Da	y, Year)	Injury	Wor	k? Yes 2 □No	Zou. Describe in	ow injury occur	160	
	after des Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injusting, etc.	ury - At ho c. (Specify	me, farm, str	eet, factory, office		28f. Location (Si City or Town	treet and Num n, State)	ber or Rura	l Route Number,
	within 24 hours after or the Funeral Discompletely filled in	Medical C		hysician: To the best miner: On the basis o and manner sta	f examina							
į	withir Comp	Me	29b. Signature and title of certifier	w.p			29c. Licens	e number	2	29d. Date signe \$\s\ \\$	ed (Month,	
			30. Name and address of person who	completed cause of d	eath (Item	23a) (Type,	Print) Place	HO854	itmor	21203		
	Sta Registr		31. Date filed (Month, Day, Year)  ALIC 1 4 201	2 Pensus	ar's Signat	ture	led					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Director    Director	3. Time of Death 6:30 AM  Death George's  Birthplace (State or Foreign Country)  I'rginia  10d. Inside City Limits 1X Yes 2 No  at Country?  American Indian,  White, etc.
Physician   Medical Examiner   Elisha   Odom   August 10, 20	Death  George's  Birthplace (State or Foreign Country)  I'rginia  10d. Inside City Limits  1 X Yes 2 No  American Indian,  White, etc.
Cherry Lane Nursing Home  Cherry Lane Nursing Home  Laurel  Prince  Funeral Director  Page 15 Social Socurity Number 224347087  See 15 Social Socurity Number 2244347087  See 15 Social Socurity Number 22434347087  See 15 Social Social See 15	George's  Birthplace (State or Foreign Country)  Irginia  10d. Inside City Limits  1 X Yes 2 No  at Country?  American Indian, White, etc.
S. Sovial Socurity Number   224347087	Birthplace (State or Foreign Country)  Virginia  10d. Inside City Limits 1 X Yes 2 □ No  at Country?  American Indian, White, etc.  1ack
Director    224347087	Inginia  10d. Inside City Limits  1 X Yes 2 No at Country?  American Indian, White, etc.
Second   S	10d. Inside City Limits  1 🛣 Yes 2 □ No  at Country?  American Indian, White, etc.
10a. State   10b. County   10c. City, Town or Location   10d. City, Middle, Andrews   10d. City, Town or Location   10d. City City City City   10d. City City City City City City City City	1
Veto Odom    Florida   Williams	American Indian, White, etc.
Veto Odom    Florida   Williams	American Indian, White, etc. 1ack
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23a. Part 1. Enjoy the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  MYOCARDIAL INFARCTION  Due to (or as a consequence of):  CORONARY ARTERY DISEASE  Sequentially list conditions, if any leading to immediate.	
23a. Part 1. Enjoy the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  MYOCARDIAL INFARCTION  Due to (or as a consequence of):  CORONARY ARTERY DISEASE  Sequentially list conditions, if any leading to immediate.	a, Zip Code)
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Sequentially list conditions, if any loading to immediate a sure of the sequence of the sequen	
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that initiated events resulting in death) Last  C. Due to (or as a consequence of):    Due to (or as a consequence of):	
The second of th	
FFMALE:	
23d. Date   Description   Desc	
The paper of the p	of delivery
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PERIPHERAL ATERIAL DISEASE  CARDUINTOPATHY  24a. Was an autopsy performed?  1   Ves 2   No 1  25. Was case referred to medical examiner?  1   Ves 2   No 1  1   Inpatient 2   ER/Outpatient 3   DO4   Other:	Day Year
PERIPHERAL ATERIAL DISEASE    1X   Yes   2   No   1	to to the enues of death?
CARDUINTOPATHY  24a. Was an autopsy performed? In yes 2 X No 1  25. Was case referred to medical examiner?  1 yes 2 X No 1  Hospital:  1 positions 2 Provide the control of	
CARDUINTOPATHY    CARDUINTOPATHY   CARDU	1
T F S 2 No 1  1 Ves 2 No 1  25. Was case referred to medical examiner? 1 Ves 2 No 1  Hospital: 1 Inpatient 2 FR/Outpatient 3 DO4  Other: AV Nivelac Horse 5 Decidence of Death (Check only one)	e autopsy findings available r to completion of cause of th?
26. Place of Death (Check only one)    Solid Check only one   Positions & Color of Death (Check only one)	Yes 2 No
5 0 0 Thinnatient 2   Fe/Cluthatient 3   Thinat   Wilhillies & Constant 2   Transit	
27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
1X Natural 5 Pending (Month, Day, Year) injury work?  2 Accident Investigation M 1 Yes 2 No	Specify)
27. Manner of Death  1 Natural  2   Accident  3   Suicide  4   Homicide  28a. Date of injury  (Month, Day, Year)  28b. Time of injury  M  28c. Injury at work?  1   Yes 2   No  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?	Specify)
S to the second	
To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one)  29a. Certifier (Check only one)  3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner only one)  3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner only one)	
only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and may 29b. Signature and title of certifier	r Rural Route Number, as stated.
	r Rural Route Number, as stated. the cause(s) and manner stated. ner as stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	r Rural Route Number, as stated. the cause(s) and manner stated. ner as stated. fonth, Day, Year)
Michael Barko M.D. 3450 Fort Meade Road Suite 209 Laurel, Maryland 2	r Rural Route Number, as stated. the cause(s) and manner stated. ner as stated.
31. Date filed (Month, Day, Year) 32. But sa's Signature	as stated. the cause(s) and manner stated. her as stated. fonth, Day, Year)
Registrar AUG 1 4 2012 Russ B. Barks	as stated. the cause(s) and manner stated. her as stated. fonth, Day, Year)

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Day Phillips Edward Aug us Medical 4a. Sacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rason 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** Months Min. 218-56-0578 Director 1 M 2 F Pege 1 and 2 should be filed within 72 hours efter death with the Maryland ment of Health and Mental Hygiene.

Tent: If item 27 is merked other then "naturel", or items 23e or 28e-f show lury or other treumatic event, the Medical Evoniner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Marc 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0~12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Somame) 17. Father's Name (First, Middle, မ 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Importent: If ite
eny injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License eral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final paninatic (antel Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin ate has been signed by the ettending physician and pege 2 should be deteched for use as the buriel-trensit The lew requires that the death certificete be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an To the Hospitel or Attending Physicien: The lew within 24 hours after death.
To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2: autopsy Hospitel or Attending Physicien: <sup>-</sup> 24 hours after death. 25. Was case referred to medical Division of Vital Be ( 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier nshujapahilMD 20057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ENH NES PICE 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) Baltimore MD 21209 5 203 NSKAJAPAKJEMD 2835 Smion 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

Birthplace (State or Foreign Country)

14. Race - American Indian, Black, White, etc.

MD

501 M

1 Yes 2 No

21218

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylan	•	artmen			and M	lental Hy	giene Reg. No	201	2 25837
			Registrar     Decedent's Name (First, Middle, Last)		imour	0. 5	-	-	2. Date of De	ath		3. Time of Death
	Physicia Medic		James Rudolph Proctor						August	08ª	<sup>y</sup> 2012	2:20 P M
3	Examin	er	4a. Facility Name (if not institution, give street and number) Holy Cross Hospital		1		Location o				. County of Dea Montgom	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. le	st birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir		9. Bir	thplace (State or Foreign
	Director		214-28-9959 1XM275	31 Yrs.	Months	Days	Hours	Min.	(Month, Da Augus t	y, Year)	Co	ryland
	nd now at	ايا	Usual Residence of Decedent	, Town or Lo	cation				August	10,	ria	10d, Inside City Limits
	larylar 3a-f sl ified i	Director	MD Prince George's Gler	narden								1 ¥ Yes 2 □ No
	the N a or 28		10e. Street and Number		10f. Zip	Code				10g. Cit	tizen of What Co	ountry?
	h with ns 23a nust l	Funeral	1420 5th St		207					USA		
	r deat or iten niner r	by Fu	11. Marital Status  1 Never Married 2 M Married  12. Was Decedent Ever in U.S Armed Forces?  1 Never Married 2 M No	- 1					cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
036	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed b	3 Widowed 4 Divorced If Yes, Give Year or Dates.	-	1 🗌 Yes	2 🕅 No	Specify:				Specify: B1	ack
2-0	2 hou "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usua kind of wo	rk done du	tion uning most	of workin	ng	16b. K	ind of Business	/Industry
121	ithin 7 ene. • than the Mo	Som	Elementary/Secondary (0-12) College (1-4 or 5+)		o <i>notu</i> se ck Ma					١ ,	Private	
d 2	filed w al Hygi d other	Be	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle,			
ylar	should be filed within 7 and Mental Hygiene. 7 is marked other than raumatic event, the M	임	Richard Earl Proctor			1	Mary	В. Ү	ates			
Maryland 21215-0036	± 0		19a. Informant's Name/Relationship (Type, Print)  Jerusha E. Proctor/Wife								Town, State, Zi	p Code)
as	1 and 2 s of Health item 27 other tra	H	20a. Method of Disposition 20b. P	lace of Dispo	sition (Nan	ne of	- :		MD 20		ocation - City or	Town, State
m <sub>o</sub>	age 1 ent of nt: If i		1X Burial 2 ☐ Cremation 3 ☐ Removal from State Resu	emetery, cren I <b>rrect</b>	natory or o ion C	ther place emete	ery 0	8-16	-2012	l	-	Maryland
Baltimore,	permit. Page 1 a Department of F Important: If ite any injury or ot		21. Signature of Funeral Service Licensee		2. Name an	d Address	of Facility	y J.3	. Jenk			Home, Inc
_	99 F # 9	Ц	rysy	1_							le, MD	20785
			23a. Part 1. Enter the deets shock of heart failure. List only one cause on each line.  Immediate Cause (Final Sepsis	i. Do not ente	er the mod	e of dying	, such as o	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
)	Medical		Immediate Cause (Final disease or condition resulting in death)  Sepsis  Due to (or as a consequence)	ence of:								13
	Examiner		Dementia									
2	e iii	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Urinary Trac		entin	n						
20	ecuter and Il-trans	Exan	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequ									
900	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	d									
9289	ificate ng phy as the	Medi	IF FEMALE:									
9 X	hat the death certificat ed by the attending ph detached for use as th		23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Feta	Ideath 3			,			1	23d. Date of de	elivery Day Year
. Box	r the a	ysic	1	eath 5 L	Other (sp	ресіту)					Wichiti	Day Four
P.O.	that the ned by e deta	by Pi	Part II. Other significant conditions contributing to death but not rest	ulting in the ι	underlying (	cause give	en in Part I	l.				the cause of death?
ds,	requires the been signer should be	ted t			-			_	1 🗆	Yes 2	□ No 3 □ F	Probably 4 🔀 Unknown
cor	law renas be	Completed							24a. Was auto	psy	prior to	topsy findings available completion of cause of
Re	sician: The law I certificate has k lirector, page 2 s		05 W							ormed? 2 X No	death?	s 2 🗆 No
/ita	ysician: s certific director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:  1  Inpatient 2	EB/Outpotion	nt 2 🗆 D(	Lou	ce of Deat			donas G	i ☐ Other (Spec	7.56.1)
of Vital Records,	ig Phy certhis neral o		27. Manner of Death 28a. Date of injury	28b. Time of injury		8c. Injury work?	at		28d. Describe			эну)
lon	eath. or: Aft the fur	ifica	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	Пусту	М		/es 2 □	No				
Division	or Att after d Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify,	me, farm, str	eet, factory	, office			28f. Location (S City or Tov			ıral Route Number,
Ω	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowl									
	the Hc in 24 l ine Fu ipletel	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination only one) 3 ☐ Certifying Nurse Practitioner: To the best of m		, death occ	urred at th	e time, dat					
	Voit Con Con Con Con Con Con Con Con Con Con		29b. Signature and title of certifier			License		. /	,	29d. Da	te signed (Mont	h, Day, Year)
			30. Name and address of person who completed cause of death (Item	23a) /Time !		000	56	06	5	7	19112	
	5		Kanwaljit Kaur Nagi 1500 Fore			Silv	er S	prin	g, MD 2	20910	)	
П	Sta Registr		31. Date filed (Month, Day, Year) 31 Registrar's Signat	· So	, No							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:15A Physician/ AUGUST 8,2012 Edward Francis Puskar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOSEPH MEDICAL CENTER TOWSON 9. Birthplace (State or Foreign If Under Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Months Director 1 X M 2 🗆 F 216-10-1163 96 02/27/1916 : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Baltimore City 1 Yes 2 No N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3512 E. Northern Parkway 21206 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 K No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer Police Department Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Puskar Eva Anna Fuchs Department of Health and I Important: If item 27 is me any injury or other trauma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Hank Puskar, Son 2434 Woodcroft Road Parkville, MD 21234 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 08/11/12 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility Leonard J. Ruck, Inc. Signature of Funeral Service Licensee Derphotolia 5305 Harford Road Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death PERITONITIS Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC KIDNEY DISEASE 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of AORTIC VALVE REPLACEMENT 24a. Was an After this certificate has autopsy perform death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certificate: To 1 Nnpatient 2 ER/Outpatient 3 DOA filled in by the funeral Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title 29c. License numbe 29d. Date signed (Month, Day, Year) 08/09/2012 D72540 30. Name and address of person who completed cause of death 81 JONATHAN DAINING, MD 7601 OSDER DRIVE TOWSON, MD 21204

Registrar's Agnature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month D1: 07a 4c. County of Death or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore, MD S. Greene If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Fore 7. Age (In vrs. last birthday) 8. Date of Birth 6 Sex 218-55-0932 1 **X**M 2 □ F 01/02/1957 BOSNIA Usual Residence of Deceden 10c. City, Town or Location ABINGDON HARFORD 1 🗌 Yes 2 🛚 10g. Citizen of What Country? 10f. Zip Code Street and Numbe APT. C 3641 WOODSDALE ROAD 21009 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) LUMBER YARD PALETTE MAKER 18. Mother's Name (First, Middle, M AISA SEHOVIC 17. Father's Name (First, Middle, Las PLEH HILMO 19a. Informant's Name/Relationship (Type, Print) DI.F.H. — SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 1314~BANYAN~CIRCLE~BEL~AIR, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State RANDALLSTOWN, MD 08/14/12 KING MEMORIAL PARK Donation 5 Other (Specify) 4300 WABASH AV 22. Name and Address of Facility Funeral Service Licensee WEST, INC. MARCH FUNERAL HOME BALTO, MD 212 Approximate Interval Between Onset and Death

8/11/12

use contribute to the cause of death?

3 Probably 4 Unkn

24b. Were autopsy findings availa prior to completion of cause death? 1 ☐ Yes 2 ☐ No

Physician/ Medical **Examiner** 

Physician/ Medical

**Examiner** 

**Funeral** Director

23a or 28a-f shov

or items

other

marked

and I

item 27 other

Department of Important: If it any injury or o once.

permit. Page 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified at

by Funeral Director

Completed

Be

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21. Sig

MD

Examine burial-tran Physician/Medical as þ Completed Be ပ Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	shock, or heart failure. List only o	olications that caused the death. Do not enter the mode of dying, such as cardiac or ne cause on each line.	Approximate Interval Between Onset and De
1	Immediate Cause (Final disease or condition	Coronary Herry Wheele -	L 1243
1	resulting in death)	Due to (or as a consequence of):	10
1		Mfocoraial Interaction -	1104
	Sequentially list conditions,	0.	
H	if any, leading to immediate cause. Enter Underlying	Due to (dr as a consequence of):	
	Cause (Disease or injury		
	that initiated events resulting in death) Last	Due to (or as a consequence of):	
	resulting in death) Last	,	
		d	
	IF FEMALE:	23c. If yes, outcome of pregnancy	23d. Date of delivery
	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 Fetal death 3 Ectopic pregnancy	Month Day Ye
	1 Yes 2 No	4 ☐ Pregnant at time of death 5 ☐ Other (specify)	
	g 🗌 Unknown	9 - Olkilowii	
	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of dea
•			1 X Yes 2 □ No 3 □ Probably 4 □ U
			77100 22110 32110223,
			24a. Was an 24b. Were autopsy findings av
•			performed? death?
			1 Yes 2 No 1 Yes 2 No
	25. Was case referred to medical	26. Place of Death <i>(Check</i>	only one)
	examiner? 1 Yes 2 No	Hospital:  1 Inpatient 2 ER/Outpatient 3 DOA Other:  4 Nursing Hor	me 5 Residence 6 Other (Specify)
	27. Manner of Death		8d. Describe how injury occurred
	1 Natural 5 ☐ Pending	(Month, Day, Year) injury work?	,,
	2 Accident Investigation		
	3 Suicide 6 Could not l	28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number
1	4 L2 Hornicide determined	building, etc. (Specify)	City or Town, State)
			d due to the equac(s) and manner as stated
	(Charle 2 Modical Evan	sician: To the best of my knowledge, death occurred at the time, date and place, an iner: On the basis of examination and/or investigation, in my opinion, death occurred at	the time, date and place, and due to the cause(s) and man
	only one) 3 Certifying Nu	se Practitioner: To the best of my knowledge, death occurred at the time, date and place	ce, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

State Registrar

24 hours a Funeral I

within 2

To the I

complex

29b. Signature and title of co

Neel Pafel P.O.

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & Grene

32. Registrar's Signature

22

AU4176435P102338

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d Per PHY G930 8/14/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mildred Α. Reinhart AUGUST 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore ST. JOSEPH MEDICAL Towson CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 216-44-0467 68 Director 1 □ M 2 🛛 F Sept. 30 1943 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Baltimore 1 Yes 2 No Maryland Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. Old York Road 21111 16425 death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🙀 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. should be filed within 72 hours after and Mental Hygiene. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mildred Casimira Nawrocki Albert Μ. Kavanaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau 16425 Old York Road , Monkton, Maryland Donald Reinhart / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
HilltopServiceCorp 1 Burial 2 K Cremation 3 Removal from State 8/18/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Ruck Towson Funeral Home 1050 York Road Towson, Maryland 21204 21. Signature of Function Scientifice is 23a. Part 1. Enter the disease, occumplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 1 Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 Natural
2 Accident 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of 29d. Date signed (Month, who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

AUG 14

MILDRED

REINHART

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ )ominavez ivas MOUTO 0420 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner General Hospital Columbia Howard County Howaro If Under 1 Year If Under 24 Hrs. ocial Security Numbe Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** Min. (Month, Day, Year) Director 20 Maryland INFANT 1 📈 M 2 🗆 F 2012 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location unk Director unkı 🗆 Yes 2 🗆 No 10f. Zip Code unk unk 10e. Street and Number 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 hispanic 1 X Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) INFANT Elementary/Secondary (0-12) INFANT INFANT INFÁNT Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) မ Wendy Dominguez Rivas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Dominguez Rivas-mother 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Tother (Specify) in state cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board Signals e of Euneral Sorvice Licensee alle, Director 655 W. Baltimore St; Baltimore, MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hreme disease or condition Medical resulting in death) Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the conditions, if any leading the conditions, if any leading the conditions, if any, leading the conditions, if any, leading the conditions, if any, leading to immediate cause the conditions of the Due to (or as a consequence of): Examine use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burla Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been signed funeral director, page 2 should be 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) AUG 1 4 2012 Columbia 100

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

7900

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#23a, perpHYS, G930, 8/24/2012, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ USIE TUTER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice/Northwest Hospiltal Randallstown Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) 423-48-9417 Director 89 1 M 2 K F 02/02/1923 Alabama or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 827 N.Augusta Avenue 21229 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black White etc. Š 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3

Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NQT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Vears Hospital Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Jenkins Hester 19a. Informant's Name/Relationship (Type, Print daughter and lis ma Uepartment of Health and Important: If item 27 is many injury or other gonce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernnadette Staten-Eváns 6702 Wilmont Dr. #204 Baltimore MD. 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/14712 1 Burial 2 Cremation 3 Removal from State Catonsville,MD. 4 ☐ Donation 5 ☐ Other (Specify) Western Star Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityChatman-Harris Funeral Home le 5240 Reisterstown Rd.Baltimore MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ disease or condition resulting in death) Cordiovasculat Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 4 Pregnant at time of death 9 Unknown signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) n 24 hours after death.

France Funeral Director: After the Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 Yes 2 No 2 Accident 3 Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F 29b. Signature and title of certifier 8/10/12 5203 Baltimore MD 21209 MSKy apartl MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith AV NS Rajapakse MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death August 1. Decedent's Name (First, Middle, Last) 16:03M **Physician** 10 2012 /Medical Facility Name (If not institution, give street and nur City, Town, or Location of Death 4c. County of Death Examiner Altimore If Under 24 Hrs. 8. Date of Birth Month, Day, 9. Birthplace (Si Age (In yrs. last birthday, **Funeral** Days 1 □ M Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ms 23a or 28a-f show must be notified at 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 IdERI USA 21205 Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status Pages 1 and 2 should be filed within 72 hours after d ment of Health and Mental Hyglene. ant: If Item 27 is marked other than "natural", or Item ury or other traumatic event, the Medical Examiner. ury or other traumatic event, the Medical Examiner. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired). 16b. Kin of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 KAMINER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) altimore, Maryland Be PENCER 2 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 21206 Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location 1 ☐ Burial 2 ☐ remation Department of 3 □Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility

PANCY m. WALLACE ture of Funeral Service Licensee FuneRAL 3405 W. FRANKlin Street M. allee Ent // the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or V and failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 15 days henorthage Intracrania ( /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, the first important of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to as a consequence of Examiner the death certificate be executed Due to (or as a consequence of): burial-Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) P.O. the 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been 8 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy page perform this certificate 2 No or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 27. Manner of Death 28b. Time of 28a, Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Funeral Director: After completely filled in by the funera Certification: Division (Month, Day Year) 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide after within 24 hours a To the Funeral C 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14/2012

Registrar

State

Baltimore

32. Registrar's Signature

MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene St.

31. Date filed (Month, Day, Year)

AUG 1 4 2012

12-05/06 Louis Eugene Sr	nith	Please Type or Print in Black Indel State of Maryland / Departm			ole.	
•		State of Marylana / Dopartin	eate of Death	Reg. N	201	2 2581
Physicia Medical Examir	ın/	Decedent's Name (First, Middle,Last)		Date of Death     Month Da	ay Year	3. Time of Death 1720 hrs
Jordal Examil	ner	LOUIS EUGENE SMITH  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl	July 31, 2012	4c. County of Death	1720 IIIS
		612 Cabin Branch Drive	Seat Pleasant		Prince George'	s
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	thday) If Under 1 Year If Under 24Hr Months Days Hours Mir		MM/DD/YYYY 9. Birth Foreign	
Director		217-64-9232   1XM 2 F 59	Yrs.	DEC 3 19	953 cou	ntry) MD
hue		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		· T	10d. Inside City Limits
■	'n	MD PRINCE GEORGE'S	SEAT PLEASANT	1		1 X Yes 2 No
Maryla	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Count	ry?
n with the Maryland ms 23a or 28a-f abo be notified at once.		612 CABIN BRANCH  11. Marital Status 12. Was Decedent Ever in U.S.	20743	posify Vos or No	USA 14. Race - Americ	on Indian Block
eath w	Funeral	1 X Never Married 2 Married Armed Forces?  1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto		White, etc.	
after c	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		Specify: BLAC	
hours "natu	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		b. Kind of Business/In	dustry
D36 thin 72 than 'than'	Completed	11th	LANDSCAPING		PRIVATE	
5-0 iled wi Hygier Jother ithe M		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	en Surname)	
2121 lid be f Mental marke event	To Be	WENDELL SMITH  19a. Informant's Name/Relationship (Type, Print )  15	ETHEL J  Ob. Mailing Address (Street and Number or		City or Town State	Zin Code)
AD 2 shou h and ? 27 is rematic			3613 HALLOWAY NORTH,			
re, rand s 1 and f Healt f fitem			of Disposition (Name of cemetery, tory or other place)	Date 20	c. Location - City or T	own, State
Page Page ment o		4 Donation 5 Other Specify: RESUR	RECTION CEMETERY 08/		CLINTON, M	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f abo injury or other traumatic event, the Medical Examiner must be notified at once.	Ц	21. Signature of Funeral Service Licensee	22. Name and Address of Facility J. 7474 LANDOVER ROA			
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do n				Approximate Interval
/Medical Examiner			Cardiovascular Disea	se		Between Onset and Death
المعمورة		or condition resulting in death)  Due to (or as a consequence of):  b.				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
<b>b</b> -	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
executed an and al - transit	ical E	d	000 0 16 10			
50, te be ex ysician			me,g930 8-16-12 sm		22d Date of delivery	
Box 68760, edeath certificate be ex the attending physician of for use as the burial.	Physician/Med	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregna		23d. Date of delivery Month Da	y Year
SOX (Jeath of attention for use	ysici	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)			
P.O. Bost that the degree by the detached for		Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	_	co use contribute to th	
S, P.C uires that n signed	ed by			1	No 3 Proba	
cords law requi	Completed			24a. Was an autopsy performed	prior to co	ppsy findings available mpletion of cause of
tal Reco cian: The law certificate has		25. Was case referred to medical	26 Place of Death (Check	1 Yes 2	No 1 ✓ Yes	2 No
Vital hysician this certi	Be	examiner?	- IOther -		idence 6 🗸 Other:	Scene
n of \ding Ph;	n: To	27. Manner of Death 28a. Date of Injury 28b.	Time of Injury 28c. Injury at Work?	28d. Describe how	injury occurred	
Sion Mitendi death. ctor:	atio	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			
Division of Vital Records, pital or Attending Physician: The law requinours after death.  reral Director: After this certificate has been sifiled in by the funeral director, page 2 should be	Certification:	Suicide Could not be determined (Specific)	farm, street, factory, office building, etc.	or Town, State)	et and Number or Rura )	al Route Number, City
E 8 E		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only)				
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner:On the basis of examination and/or and manner stated				
	≊	29b. Signature and title of certifier	29c. License number O.C.M.E.		d. Date signed <i>(Mont</i> ugust 1, 2012	h, Day, Year)
4		30. N me and do ass of person who completed cause of death (Item 23a)			-340. 1, 2012	
4		Pamela E. Southall, MD Assistant Medical Examine	er 900 W. Baltimore Street, Balti	more, MD 2122	3	,
St Regist	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	W			•
regist	للخد	HANT - PAIR MANAGE L.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death AMONTH AUGUS Physician/ Esther Marie Smoke Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner (IENTE TIMORE 1EDICAL IDWSON 9. Birthplace (State or Foreign 5. 381 Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days (Month, Day, Year) Country) <del>387</del>-07**-**6560 Director 95 1 - M 2 XX F November 8,1916 Pennsylvania 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Direct 1 Yes 2 XNo Baltimore Towson Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 United States 6 Sonachan Ct. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Yes 2 X No 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဨ Marie Ann Branks John L. Kline permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 Sonachan Ct. Towson, MD 21286 19a. Informant's Name/Relationship (Type, Print) Towson, MD Susan Clark/daughter 6 Sonachan Ct. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Aug. 14,2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee John O. Mitchell IV, Funeral Services of Dulaney 200 E. Padonia Rd. Timonium, MD 21093 Valley Mutchel Vallév.P.A. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 16NAK disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23h Was decedent pregnant

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1  Live Birth 2 Li Feta 4 Pregnant at time of c 9 Unknown					Month	Day	Year		
Part II. Other significant conditions ATRIAL FIBRILL	ATL	ON WITH RAP	Pid Centre	cul	ar Kespors		ouse contribute to 2 ☑ No 3 ☐ F				
ACUTE ON C		PONIC REN	DAL FA	tiù	IRE	24a. Was an autopsy performed/	death?	topsy finding completion of s 2 No			
25. Was case referred to medical	Т										
examiner? 1 Yes 2 Ano	Но	spital:	lome 5 Residence	6 Other (Spec	cify)						
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat	tion	28a. Date of injury (Month, Day, Year)	28b. Time of injury	284 M	c. Injury at work? 1  Yes 2  No	28d. Describe how inj	8d. Describe how injury occurred				
3 Suicide 6 Could no 4 Homicide determine		28e. Place of Injury - At ho building, etc. (Specify		factory,	office	28f. Location (Street : City or Town, Sta		ural Route Nu	mber,		
29a, Certifier 1 Sertifying P	hvsic	ian: To the best of my know	ledge, death occu	rred at t	he time, date and place,	and due to the cause(s	and manner as s	tated.			

		1
81		30:N
Ctat	-	31. D

Medical

(Check only one

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of

29d. Date signed (Month, Day, Year)

ame and attracts of person who completed cause of death (Item 23a) (Type, Print)

completely

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 09 Aug. 7:30 A Shufford Louis Edward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore 5306 Morello Road If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 08-27-36 Hours Country) 75 Director 219-32-9174 NC 1 1 M 2 □ F 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State filed within 72 hours after death with the Maryland Director Baltimore 1 Yes 2 No NA MD 10f Zin Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21218 1522 Lakeside Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Wes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) NA Trucking Company Truck Driver 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental h Mae ပ Ethel Shufford Samue1 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5306 Morello Road Baltimore, Maryland 21214 Louis M. Shufford, Sr.-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 a Department of H Important: If ite any injury or otl IX Burial 2 ☐ Cremation 3 ☐ Removal from State 08-17-12 Owings Mills, MD Garrison Forest 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. Street Baltimore, Maryland 21217 Gilmor 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a continuuence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to jur as a Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death detached the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in Completed by ate has been signed page 2 should be 1 Yes 2 No 3 Probably 4 Number 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pag 1 ☐ Yes 2 🂢 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 X No 3 DOA မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Nother (Specify) Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of fertifier License number 29d. Date signed (Month, Day, Year)

7∤\√ State

Registrar

DHMH 17 Rev 06-2011

MD Garwyn Medical Center 2300 Garrison Blvd. Baltimore, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Rifat Abousy,

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 25848

		or State	Certificate	e of Death	Reg. No.  2. Date of Death	3. Time of Death
Physician/	1. D	strar ecedent's Name (First, Middle,Last)			Month Day Year August 8, 2012	1609 hrs
Examiner		AlVAT SIME	1500/		August 8, 2012	
LAG	12	Facility Name (if not institution, give street	et and number)	4b. City, Town, or Location of Death	4c. County of De	, aut
		Mercy Hospital		Baltimore	10//4	
		· · · · · · · · · · · · · · · · · · ·	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9.	Birthplace (State or oreign
Funeral	5. 8	ocial occurry manual	1.1 /Y	Months Days Hours Min.	1/17.19,	Country) MD
Director	21	14-674-21974 1 M	2 F 79	Yrs.	10011	
	Ust	ual Residence of Decedent	10c. City, Town or L	ocation		10d. Inside City Limits
any	10a	a. State 10b. County	10c. City, Town of L	Ti 22		1 Yes 2 No
	1	MMD. N/A	T/AL	1/1/ (OVE	10g. Citizen of What 0	Country?
Maryland 28a-f show d at once.	106	a. Street and Number		10f. Zip Code	10g. Citizen of What	n southly:
death with the Maryland or items 13a or 28a-f sho must be notified at once -uneral Director	'``	1111 1/ 1/11/	TON 15T.	21227	4171	7
ith the 23s or notific	L	711 101 VAIV	Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? ( Sp	pecify Yes or No- 14. Race - A	merican Indian, Black,
ms 23 be no be no	11.	IVIailitapolatus	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, e	21)/
r death v or item:	1	1	Yes 2 No	1 Yes 2 No specify:	Specify:	THACK
Y ler o		Widowed 4 Divorced If Ye		cedent's Usual Occupation (Give kind of v	work done 16b. Kind of Busin	ess/Industry
5-0036 led within 72 hours after Etygiene. other than "natural", the Medical Examiner Completed by		5. Decedent's Education (Specify only his	dur	ring most of working life. DO NOT use reti		T land
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5-0036 ed within 72 hour lygiene. tother than "natt the Medical Exan Completed	17	. Father's Name (First, Middle, Last)		18.Mother's Name	(First, Widdle, Walger Garrant)	. 1
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D 21 should and Me	1	720615 V. GOL	165 13	302 WILNELLE	1 VVDV IUN 1	IVI FIII
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-fah ar anther traumatic event, the Medical Examiner must be notified at sonce ar ather traumatic event, the Completed by Funeral Director	20	Da. Methed of Disposition		Disposition (Name of cemetery,	Date 20c. Location - C	ity or 1 own, State
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other travus		Burial 2 Cremation 3	Pamovai from State i Zi	y or other place)	-17-12 Was Im	M5/2R/W
ages ant o	1	Donation 5 Other Specify:	CANTAIN		- Ot - WI THE Whi	1200
	2	1. Signature of Funeral Service Licensee	/	22. Name and Address of Facility	TO THE PROPERTY OF	mit with
Balti permit. Departi Impurt injury		Vary 17- 11 /ave		CAPY YIMARCH MI	as respiratory arrest, shock or hear	Approximate Interval
hysician	2	3a. Part I. Enter the disease, or complicat	tions that caused the death. Do not	enter the mode of dying, such as cardiac	or respiratory arrest, shoot, or mean	Between Onset and Death
Medical		failure. List only one cause on each	arcotic Intoxicat			Death
Examiner	li c	mmediate Cause (Final disease a. No or condition resulting in death)	e to (or as a consequence of):			
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,	<u>.</u>   §	Sequentially list conditions, f any, leading to immediate  Due	e to (or as a consequence of):			
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60, ate be executed obysician and te burial - trans	<u> </u>	X UNPENDED	$_{AMENDED}$ 23a, pt. $II$ , 2	7,28a-f,per me,g932	2 10-1-12 Sm	
60, ate be e shysicia	51		23c. If yes, outcome of pregnancy		23d. Date of c	delivery
	<u> </u>	E ECMALE:		Fetal death 3 Ectopic preg	nancy Month	Day Year
76 ficate g phy	- 14	3b. Was decedent pregnant in the	1 Live birth 2		indirey	Day Year
6876 certificate nding phy		3b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time of death 5			Day Year
cax 6876 eath certificate at tending phy for use as the	sician/	3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown	1 Live birth 2 4 Pregnant at time of death 5	Other (Specify)		
Box 6876 the death certificate y the attending phy ched for use as the l	sician/	3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions	1 Live birth 2 4 Pregnant at time of death 5 9 Unknown ontributing to death but not resulting	Other (Specify)  in the underlying cause given in Part I.	23e. Did tobacco use contrit	oute to the cause of death?
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Records, P.O. Box 687 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:	ompleted by Physician/	3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknown  Part II. Other significant conditions of the Hypertensive Ath	1 Live birth 2 4 Pregnant at time of death 5 9 Unknown ontributing to death but not resulting	Other (Specify) g in the underlying cause given in Part I. ediovascular Disease 26 Place of Death (Che	23e. Did tobacco use contrit  1 Yes 2 No 3  24a. Was an autopsy performed? 1 Yes 2 No 1  ck only one)	pute to the cause of death?  Probably 4  Unknown  Vere autopsy findings available nor to completion of cause of eath?  Yes 2 No
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12-06030 Michael Schillinberg

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 25849

		1- For State Registrar	,	Cer	tificate of	Death		R	eg. No.	I L L U U T	
Physicia		Decedent's Name (First, Mid-	dle,Last)					2. Date of Dea Month		3 Time of Death	
ledical Examir		Michael J.	Schillinb	erg		_		August 12	2, 2012	0245 hrs	
The state of the s		4a. Facility Name (if not institut		mber)		4b. City, Town, or Lo	ocation of Dea	ath	4c. County of D		
		431 N. Highland Ave				Baltimore				N/A	
<b>Funeral</b>		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24H Hours M	Irs. 8. Date of Bi	rth(MM/DD/YYYY) 9	Birthplace (State or oreign	
Director	- 1	218-15-8647	1X M 2 F	40	Yrs	Months Days	Hours	09/24/1		Country)Georgia	
	ŀ	Usual Residence of Decedent	1-11								
any	Ī	10a. State 10b. County	У	10c. City,	Town or Locat	ion				10d. Inside City Limits	
pp <b>po A</b>	_	Maryland	N/A	Ra1+	imore					1 X Yes 2 No	
faryland  28a-f show	윉	10e. Street and Number	IV/A	1 DILL	<u> </u>	10f. Zip Code			l0g. Citizen of What	Country?	
with the Maryland ms 23a or 28a-f sho he notified at once	Director	405 Church Street	-			2122	5		11.9	S.A.	
ith ti		11. Marital Status		edent Ever in U.	S. 13. Wa	is Decedent of Hispa		Specify Yes or No		merican Indian, Black,	
ath w	uneral	1 Never Married 2 X	Married Armed Fo	rces?		es, specify Cuban, I			White, e	tc.	
or or	뜨ㅣ	3 Widowed 4 D	1 Yes	2 X No	1	Yes 2X No	specify:		Specify:Wh:	ite	
rs aft	<u>م</u>	15. Decedent's Education (Sp	or Dates:		16a. Deceder	it's Usual Occupatio		of work done	16b. Kind of Busin		
"nat	Completed	Elementary/Secondary (0-12			during m	ost of working life. I	OO NOT use r	retired)			
5-0036 led within 72 hou Hygiene. lother than "nat	릛	12	N/A		Se1	f Employed			Welde	r	
5-0036 ed within 7. Hygiene. other than the Medical	ē	17. Father's Name (First, Middle					Mother's Na	me (First, Middle,	Maiden Surname)		
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be	Stephen	Schillinberg			l <sub>De</sub>	eborah	L.	Irvine		
D 21215-00; should be filed withi and Mental Hygiene 7 is marked other til	ם	19a. Informant's Name/Relation			19b. Mailing				mber, City or Town,	State, Zip Code)	
MD dd 2 shoulth and lith and an a7 is	-	Deborah Schillin	berg (Mother)		36 Los	Alamitos C	ircle Ha	nover, Per	nsylvania 1	7331	
more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-fah or other traumatic event, the Medical Examiner must he notified at once	ŀ	20a. Method of Disposition			lace of Dispos	sition (Name of ceme		Date	20c. Location - Ci		
OFE ges 1 r of F		1 Burial 2 X Crematic	on 3 Removal fro	JIII State	rematory or ot		000	/10 /0010	C1 D	M1 d	
timen rtant	ļ	4 Donation 5 Other 3	Specify:		antic Cr	emation Jame and Address o		/13/2012	Gren Burni	e, Maryland	
Baltimore, MC permit. Pages 1 and 2 s Department of Health as Important: If item 27 injury or other traum!		21. Signature of Funeral Service	ce Licensee [v]	00-732	Ma	Cully-Polyn:	iak Fune	eral Home.	P.A. oryland 2112	0	
	4	23a, Part I. Enter the disease, of	or complications that ca	aused the death	Do not enter t	<u>04 Mountain</u> he mode of dying si	Road Pa	sadena. Ma	arytand ZIIZ rest. shock, or heart	Approximate Interval	
Physician /Medical	١	failure. List only one caus	se on each line.							Between Onset and	
Examiner	-	Immediate Cause (Final disease or condition resulting in death)				on (Methad	one,Tr	amadol,a	nd Alprazol	am)	
	- 1	or condition resulting in death)	Due to (or as a	consequence of	):				·		
	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of					-		
	틭	cause. Enter Underlying Cause  Clisease or injury that initiated c.									
	Examiner	events resulting in death) Last									
760, ciate be executed physician and the burial - transit			d. 220 27 280 f por mo c020 8-20-12 cm								
oe exe	edical	VNPENDED									
760, icate be physici	21	IF FEMALE: 23b. Was decedent pregnant in	the C	outcome of pregr	·		7		23d. Date of de		
68 Se as	Ë	past 12 months?	1	ırth ant at time of de	ath - =		Ectopic pres	gnancy	Month	Day Year	
Box 687 c death certifithe attending ped for use as t	Physician/	1 Yes 2 No 9 U	Inknown 9 Unkno		o	ther (Specify)					
P.O. Be that the de ned by the	됩	Part II. Other significant cond	ditions contributing to	death but not re	esulting in the	underlying cause giv	en in Part I.	23e. Did 1	obacco use contribu	te to the cause of death?	
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1 Of ling Pt After funeral	اڃ	27, Manner of Death		of Injury , Day,Year)	28b. Time of				how injury occurred		
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ViS or At firer of Direc	ij	=	ould not be 28e. Place	e of Injury - At ho	ome, farm, stre	et, factory, office bu	ilding, etc.			or Rural Route Number, City Highland Ave.	
Division pital or Attent ours after death teral Director:	Certification:	4 Homicide	termined (Specify)			owhouse		Baltim	ore,MD.		
Hos 24 h Fun		29a. Certifier 1 Certifying	Physician. To the bes	t of my knowled	ge, death occu	rred at the time, date	and place, a	and due to the cau	ise(s) and manner as	s stated	
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	Σ	29b. Signature and title of certi	ifier			29c. License				(Month, Day, Year)	
		Paner & Runth	all mi			O.C.M	I.É.		August 12, 2	012	
9		30. Name and address of person	on who completed caus	se of death (Item							
Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											
	ate		17) 32. Re	egistrar's Signatu	ire						
Regist	rar	AUG 1 4 2012	Buch	A	arked			<del> </del>			
DHMH 17 Rev 1/20 OCME 2006	001		`	. ,	ORIGINA	<b>L</b>			OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 55 01 Medical 4a. Facility Name (if not institution, give street and number), Examiner 4b. City. Town, or Location of Death 4c. County of Death tos 108 If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 7. Age (In vrs. last birthday If Under 1 Year **Funeral** 8. Date of Birth 03/03/1953 Min 1 X M 2 D F 212-60-4109 59 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 921 Elton Avenue 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates ☐ Yes 2X No "natural", Specify 3 Widowed 4 X Divorced Completed White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Mechanic Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ray Smith Sarah Bolling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Hippler / Sister 305 Trappe Road, Baltimore, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 8/10/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final EMENEIA hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy
☐ Other (specify) \_\_\_\_ in the past 12 months? jo Day Month Year Pregnant at time of death 2 No the 9 Unknown Unknown P.O.1 þ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alcohol Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy certificate 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Division of Vital Be funeral director, 26. Place of Death (Check only one) ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrat's Signature

101

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 9, Ruth Sharp 10:00a M 2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 216-32-2326 Director February 26, 1930 Germany 1 M 2 XF 82 Yrs. Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Md. Baltimore Dundalk 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8236 North Boundary Road 21222 Apt. C USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No ģ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White Completed 3 Widowed 4 X Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home 2 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3433 Beckleysville Road, Parkton, Md. 21120 Doris Kammer Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 August 10, 0:00 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service License Connelly Funeral Home of Dundalk, P.A. 101176 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate mmediate Cause (Final Physician/ Medical PULMONARY disease or condition resulting in death) Due to (or as a consequence of) **Examiner** Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exam requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death ed by the a Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tyes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown After this certificate has been sifuneral director, page 2 should AUGUST 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Cher (Specify) Hospital 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ RUTH SHARP completely filled in by the funeral 28c. Injury at . work? 1 \square Yes 2 \square No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending death. Investigation Accident 24 hours after death Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32. Registrar's Signature

JUNECIA WHITE,

4 2012

29c. License number

2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 08<sup>Bay</sup> Physician/ Month 08 Shah 20Î2 Khatoon 3:31p. M Atia Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Catonsville 1509 Adamsview Road If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** 03 05 39 Davs Hours Min Country) 73 1 □ M 2 🔏 F Director Usual Residence of Deceden or 28a-f show e notified at 10h County 10c. City, Town or Location 10d Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 X No Catonsville Baltimore MD t 23a o, 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21228 Pakistan 1509 Adamsview Road must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Examiner Black, White, etc. "natural", or 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 Asian 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced Completed and Mental Hygiene.

is marked other than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher 12th grade other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) Unknown 17. Father's Name (First, Middle, Last) should be filed Syded Maqbool Ahmed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 Adamsview Road, Catonsville, Md 19a. Informant's Name/Relationship (Type, Print) 21228 permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Imran Shah-Son 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 8/9/2012 Woodlawn, Md King 4 Donation 5 Other (Specify) 21. Signature Funeral Service 22. Name and Address of Facility
March F/H West 21215 Baltimore, 300 Wabash Ave, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause in each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ ray we disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): death certificate be executed and -trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 Month Day Year Pregnant at time of death signed by the at Id be detached for g Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No after death. Director: After this certificate Yes 2 or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 \( \sum \) Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of D ath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? iniury 5 Pending Investigation Accident filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital
within 24 hours a
To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation. In my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year, 29b. Signature and title of cert who completed cause of death (Item 23a) (Type, Print) MD GOG5 Manshalee Dr. Elkvidge haves M. tarris Month, Day, 32. Registrar's ignature State

Registrar

AUG 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 08<sup>ay</sup> Hogeth Both 2012 4:48р. м Siddiqui Zulekha Begum 4c. County of Death Howard 4b. City, Town, or Location of Death Columbia 4a. Facility Name (if not institution, give street and number) Lorien Nursing Home Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) (Month, Day, Year) Days Hours 215-25-6360 1 🗆 M 2 🗶 F 23 India 06 15 89 10d. Inside City Limits 10b. County 10c. City, Town or Location Ellicott City 1 🗌 Yes 2 🎇 No Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A 21043 8484 Oak Run Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Yes 2X No Yes, Give Specify: Asian 1 ☐ Yes 2 【XNo Specify: 3 🔀 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12)
12th grade College (1-4 or 5+) Unemployed Unemployed 18. Mother's Name (First, Middle, Maiden Surname) Unknown 17. Father's Name (First, Middle, Last) Abdual Quder Siddiqui 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8484 Oak Run Way, Ellicott City, Md 21043 19a. Informant's Name/Relationship (Type, Print) Rafia Siddiqui-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 8/9/2012 |Woodlawn, Md 21. Signal of Fuperal Service Ligensee 22. Name and Address of Facility
March F/H West Raltimore

Proviction Medical **Examiner**  1 - State Registrar

MD

Physician/

Medical

Director

Funeral

þ

Completed

Be

2

**Examiner** 

**Funeral** 

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

and physician use as the a signed by tl been signal s certificate has b director, page 2 s s after death.

I Director: Aft
d in by the fur within 24 hours after

To the Funeral Directory filled in b

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

			4300 Wabash Ave		) L C / 11G	22211
al Examiner		cations that caused the death. Do not	enter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death
a by Physician/inedic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	4 Pregnant at time of death 9 Unknown	3  Ectopic pregnancy 5  Other (specify)			very Day Year  he cause of death?
pe complete	25. Was case referred to medical		26. Place of Death (Chec.	24a. Was an autopsy performed? 1  Yes 2	prior to co death?	opsy findings available ompletion of cause of
e: 10	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	lospital: 1	ne of 28c. Injury at	ome 5 Residence 28d. Describe how inj		y).
edical Certificat	3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physic	28e. Place of Injury - At nome, farm building, etc. (Specify)	eath occurred at the time, date and place, a	28f. Location (Street a City or Town, Sta	and manner as sta	ted.
ed	(Check 2 Medical Examine	er: On the basis of examination and/or in Practitioner: To the best of my knowle	nvestigation, in my opinion, death occurred a edge, death occurred at the time, date and pl	it the time, date and pla ace, and due to the cau	ce, and due to the ca ise(s) and manner as	stated.

29c. License number

29d. Date signed (Month, Day, Year)

August 8th 2012 BALTIMORE MD 2120

State

Registrar

29b. Signature and title of Artifier

Q.

31. Date filed (Month, Day, Year,

ABBAS

4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

32. Registrar Signature

N CHARLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death :45 AM Physician/ St Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Darlington 4104 Conowingo Road, #18 8. Date of Birth (Month, Day, Year) 08/26/1937 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Country) Maryland Days Months 1 M 2 □ F Director 216-32-4541 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Modical Experient reast be notified at Director 1 X Yes 2 ☐ No Darlington MD Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21034 USA 4104 Conowingo Road, #18 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. 1 Nair Force δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced Completed White ar or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4 or 5+) Local Government Firefighter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٥ Edna McKenzie Stanley Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau once. 5604 Carrington Drive, White Marsh, MD 21162 John Snyder / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 8/11/2012 Beltsville, MD Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Physician/ 400 disease or condition Medical resulting in death) Due to (or wa a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events septible in death). Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 \( \sum \) Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident 5 Pending Investigation 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier

MSTRY FAMILIAND 29d. Date signed (Month, Day, Year) 00057465 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X 21209 Rajapakzemo 2835 Smith

State Registrar 31. Date filed (Month, Day, Year)

2012

32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Smith Herbert Edward 20 12 August 10:20 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 312 Plumtree Rd. Bel Air Harford Social Security Number lf Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Hours Min Days **Director** 316-30-6065 1 XM 2 - F 78 Mar. 15, 1934|Indiana Usual Residence of Dece 28a-f show 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Bel Air Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 312 Plumtree Road 21015 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner rmed Forces?

XYes 2 \sum No Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced Specify. Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Electrical Engineer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert Frederick Smith Helen Marie Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Katherine Smith / Spouse 312 Plumtree Road, Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Chapel UMC Cem. 8-15-2012 Joppa, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. Funeral 21. Signatur rvice Licer 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause on nati catu n earch ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cene disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit -tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

(Check

29b. Signature and title of certifier

<u>Venkata Krishna J</u>

AUG 1 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

510 Upper Chesapeake Dr.,

29d. Date signed (Month, Day, Year)

Bel Air.

MD 21014

V3

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Suite 409.

Smith Patricia

		4	For State	State of M	laryland / Depa	artment of H <i>tificate of L</i>			21	112 2585
			Registrar  1. Decedent's Name (First, Middle, La	st)	- Cer	uncate of L	Jeann	2. Date of Dea		3. Time of Death
п	Physicia Medic		Patricia Elaine	Smith				Month	/O a	2012 7:52 P
The state of the s	Examin	er	4a. Facility Name (if not institution, giv		0 101		Location of Death		4c. County	of Death
	Funeral		5. Social Security Number 6.		ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	Birthplace (State or Foreig Country)
	Director			1 □ M 2 🛛 F	72 Yrs.	Months Days	Hours Min.	(Month, Day Apr. 8		Maryland
	ind show at	'n	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryla 28a-f s otified	irect	Maryland Baltimo	re	Baltimor					Yes 2 N
	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	10e. Street and Number 523 Patapsco Av	7 <del>0</del> .		10f. Zip Code 21237			10g. Citizen of USA	What Country?
	eath wi	nne	11. Marital Status	12. Was Decedent		Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		ce - American Indian,
36	ofter de ", or it		1 Never Married 2 Married	Armed Forces'  1 Yes 2 If Yes, Give	56 in	1 Yes 2 No		riican, etc.)	Specify	ck, White, etc. : <b>White</b>
21215-0036	atural	Completed	3 Widowed 4 Divorced  15. Decedent's	Year or Dates. Education	16a. Dece	dent's Usual Occup	pation		16b. Kind of E	Business/Industry
215	iin 72 h ie. han "n e Medi	dwo	(Specify only highest of Elementary/Secondary (0-12)	rade completed)  College (1-4 or	5+) life. D	O NOT use retired)	during most of worl	king	Tncura	nce Company
121	ed with Hygien other ti	as l	17. Father's Name (First, Middle, Last		Supe	ervisor	18. Mother's Nan	ne (First, Middle,		
land	should be filed within 73 and Mental Hygiene. is marked other than aumatic event, the Me	인	Joseph Leonard					eth Cath		
Maryland	should and M is mai		19a. Informant's Name/Relationship				and Number or Rui			
e,	and 2 s Health a em 27 i		Wayne Edwards-St	mith / Son	20h Place of Disne	osition (Name of		Date Aber		aryland 21001  - City or Town, State
nor	ent of ent of nt: If it		1 Burial 2 XCremation 3 4 Donation 5 Other (Spe			matory or other pla L Svcs, I	EC 8-14	-2012	Bel Ai	r, Maryland
Baltimore,	permit. Page 1 and 2 s Department of Health i Important: If item 27 any injury or other tra		21. Signar reof Funeral Service Lice		,	2. Name and Addre	ess of Facility Mo	oComas F ad, Abin	uneral gdon, M	Home, P.A. ID 21009
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caus one cause of each li	ed the death. Do not entine.	er the mode of dyi	ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
was	Physician/ Medical		1mmediate Cause (Final disease or condition resulting in death)	a Fatal	A CC h y 1 s a consequence of).	hmia				Offset and Death
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	_ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dao 10 (01 a	s a consequence of):					
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09	be existing the property of the second secon	dical		■ d						
6876	tificate ng phy s as the	Med	IF FEMALE:							
Box 6	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and stell filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcom  1  Live Birtl  4  Pregnant  9  Unknown		☐ Ectopic pregnar ☐ Other (specify) _	ncy			ate of delivery Ionth Day Year
P.O.	es that the deal signed by the a l be detached f	/ Phy	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause g	jiven in Part I.	23e. Did t	obacco use cor	ntribute to the cause of death?
	uires th	q pa						1 🗆	Yes 2 No	3 Probably 4 Unknow
corc	aw require as been si 2 should I	Completed						24a. Was auto	psy	. Were autopsy findings availabl prior to completion of cause o death?
Re	: The Is cate h;	Con					10 11 (0)	1 Tes	2 No	1 Yes 2 No
fital	Physician: The law this certificate has ral director, page 2	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	atient 2 ER/Outpatie	Ot	Place of Death (Che	Home 5 Resi	dence 6 🗆 Ot	her (Specify)
of \	ding Phy th. After this funeral o	te: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of in (Month, L		of 28c. Inju	ıry at rk?	T	how injury occu	
ion	l or Attendir after death. Director: Af d in by the fu	Certificate:	2 Accident Investigat 3 Suicide 6 Could no	t be	Injury - At home, farm, s		Yes 2 No	28f Location (	Street and Num	ber or Rural Route Number,
Division of Vital Records,	al or A after I Direct		4 Homicide determine	building,	etc. (Specify)	,		City or To		
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	Ohnel O Medical Eve	minor On the bacie of	of my knowledge, death	estigation in my only	nion, death occurred	at the time, date	and place, and c	lue to the cause(s) and manner st
	To the H within 24 To the F complet	Me	only one) 3 Certifying N 29b. Signature and title of certifier	urse Practitioner: To	the best of my knowledg	e, death occurred a	t the time, date and see number	place, and due to	the cause(s) and	manner as stated.  ed (Month, Day, Year)
	r > r &	,	MINH	1	ND	Do	699190		8/10/	9019
	(6 Q		30. Name and address of person wh		of death (Item 23a) (Type,			-		
		10	Dr. Jonathan 31. Date filed (Month, Day, Year)	Hansen 12. Regi	9000 Fra	nklin 59	ware Dr	we ba	1+1mo	re, MD 2123
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 ÎZ 8:17 Audrey Larack Stone August A MMedical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Medstar Montgomery Medical Center Montgomery 01ney Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours 112-16-1509 **Director** 1 □ M 2 🗓 F 85 January 28, 1927 New York Usual Residence of Decede 28a-f show 10c. City, Town or Location 10d. Inside City Limits at 10a. State the Maryland Director items 23a or 28a-f s er must be notified 1 Yes 2 X No Maryland Howard Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21771 United States 1801 Long Corner Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian "natural", or item edical Examiner r Armed Forces?

1 Yes 2 No Black. White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates White Completed 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry
Public Service other than " Elementary/Secondary (0-12) College (1-4 or 5+) Research Biochemist Department of Health and Mental Hy Important: If item 27 is marked othin any injury or other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin and once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Evelyn Garcy Frank Larack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1795 Long Corner Road, Mt. Airy, Maryland 21771 Andrew Larack Stone / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) August 10, 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Functal Service License Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Dav Pregnant at time of death 5 Other (specify) ed by the at detached f signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PHROXYSMA1 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 1 Yes 2 No After this certificate Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifies funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completely filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signatore and title of certifi 29d. Date signed (Month, Day, Year) D36252 4UGV87 08, 2012 Oh

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who con

31. Date filed (Month, Day, Year)
AUG 1 4 2012

T. KARIYAMD

Sinature

Neted cause of death (Item 23a) (Type, Print) 10605 CON CORD ST#500 KWSINGTON MD 20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 State of Maryland Department of Health and Mental Hygiene 2012 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 AUGUST 7:50 A M TEMPLEMAN MALCOLM В. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY BETHESDA 5101 RIDGEFIELD ROAD # 317 If Under 1 Year If Under 24 Hrs. (Month, Day, Year 931 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Director 143-24-5439 1**X** M 2 □ F 70 Oct. 10, <del>1941</del> Newark, NJ show or 28a-f shov notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director Hyattsville Prince George's 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral USA 20783 811 Somerset Place Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: **Black** 3 Widowed 4 Divorced Completed 1956 Year or Dates the Medical 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' ury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Government Research Chemist 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Lavinia Porter Bushrod Templeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Somerset Place Hyattsville, MD 20783 19a. Informant's Name/Relationship (Type, Print) Loutishia T. Templeman/Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State George Washington Cem 08-16-2012 Adelphi, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. Signature of Funeral Service Licensee 7474 Landover Rd. Hyattsville, MD 20785 er the disease, or complications that caused eart failure List only one cause on each line , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disea shock, of Immediate Caus nterval Between Onset and Death se (Final Physician/ a Advanced Dementia disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Alzheimer's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Chronic Kidney Disease Cause (Disease or injury that initiated events resulting in death) Last burial-trar physician and Due to (or as a consequence of) Physician/Medical Diabetes Mellitus Type II Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Hyperlipidemia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other:  $_{4}$   $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) Hospice1 🔲 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 🛚 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number R11G833 August 09, 2012 emoll 30. Name and address of person who completed cause of peath (Item 23a) (Type, Print) 15245 Shady Grove Rd Stel30 Rockville, MD 20850 Lemoll Johny, C.R.N.P.

State

Registrar

AUG 1 4 2012

31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ August 1, 6:25  $\mathbf{P}$ M Desta G. Tegne Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Wheaton Manor Care If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 0972671916 Ethiopia **Director** 216 51 4693 1 3 M 2 🗆 F Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland Director must be notified Silver Spring MD Montgomery 1 X Yes 2 No 10f. Zip Code 20904 ö 10e. Street and Number 10g. Citizen of What Country? Funeral 531 Randolph Village items 23a 45A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. 10 · þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Tho Specify If Yes, Give Year or Dates Specify: Black "natural", Completed 3 Widowed 4 Divorced and Mental Hygiene.

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Gate of Heaven Cem. 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State 08/04/2012 Silver Spring, Maryland 4 Donation 5 Other (Specify). 22. Name and Address of Facility John T. Rhines Funeral Home Mature Funeral Service License 3005 12th St., NE Washington, DC M01592 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cerebral Vascular Disease Medical Due to (or as a consequence of) **Examiner** Dysphagia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) executed Cause (Disease or injury and -tran: that initiated events resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director, After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 K No 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) eral Director; After thi filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 🔀 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d, Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Georgia Ave.

Merlyn Vemury, MD 9801

31. Date filed (Month, Day, Year)

D35791

Suite 227 Silver Spring MD 20902

12

State

Registrar

DHMH 17 Rev 1/2001 OCME 2006

4

29b. Signature and title of certifier

Zabiullah Ali, M.D.

and manner stated

Assistant Medical Examiner

32. Registraris Signatu

30. Name and address of person who completed cause of death (Item-23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

August 4, 2012

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of Maryland / [	Department of H Certificate of D			2012	25862						
			Registrar  1. Decedent's Name (First, Middle, Last)	7	Certificate of L	Calli	Reg. No. 2 2. Date of Death 3. Time of Death								
	Physicia Medic		Kalph 1	aulos		Month / C	Day Year 2012	11:48 AM							
A	Examin		4a. Facility Name (if not institution, give st			Location of Death		4c. County of Death							
كمرسي	<b>-</b>		4515 Valleyview  5. Social Security Number 6. Sex			altimor If Under 24 Hrs.	e 8. Date of Birth	9 Birth	place (State or Foreign						
	Funeral Director			IM OF	Yrs. Months Days	Hours Min.	(Month, Day, Yea		ntry)						
	show dat		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		•		10d, Inside City Limits						
	arylan a-f sh ffied a	Director	MD		imore				1 🏿 Yes 2 🗆 No						
	the M or 28		10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Cou	ntry?						
	n with	Funeral	4515 Valleyview	Ave.	_	1206		USA							
9036	is filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	þ	11. Marital Status  1  Never Married 2  Married 3  Widowed 4  Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2√√ No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:Black							
21215-0036	within 72 hou giene. Ier than "natu It, the Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)	e completed)  College (1-4 or 5+)	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired)	luring most of worki	ing	o. Kind of Business Ir							
d 2	filed within al Hygiene.	Be C	6 17. Father's Name (First, Middle, Last)	Co	onstructio 		e (First, Middle, Maid	Bethlehen Hen Surname)	1 Steel Co						
lan		욘	Benjamin D. Ta		,	Rebec	ca Kelly								
Maryland	and and is m		19a. Informant's Name/Relationship (Type	e, Print) (daughter	Mailing Address (Street a	and Number or Rura	l Route Number, City	y or Town, State, Zip	Code)						
	and Heal em (		Ada Taylor Wil.  20a. Method of Disposition	liamson	5513 Edna f Disposition (Name of	Ave. Ba	lto.Md.	21214 Location - City or T							
Baltimore,	. Page tment c tant: If jury or		1 ☐ MSurial 2 ☐ Cremation 3 ☐ XF 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State cemeter Savai	ry, crematory or other plac nnah Creek	cem.	18,2012	Jamestov	n,S.C.						
Bal	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licenses		CalVIN 1412 E.	<u>Preston</u>	St. Bal	ral Home	21213						
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused the death. Do recause on each line.	not enter the mode of dying	g, such as cardiac c	or respiratory arr	,	Approximate Interval Between Onset and Death						
	Phynician/ Medical	9.7	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):												
-	Examiner														
		iner	if any, leading to immediate cause. Enter Underlying												
	cuted and transit	Examine	Cause (Disease or iinjury that initiated events	Due to (or as a consequence	of.	·····									
	ate be executed hysician and the burial-transit	dical E	resulting in death) Last		51).										
190	icate by physis the						· -								
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	ÿ 		23d. Date of delivery Month Day Year								
Js, P.O.	requires that the der been signed by the s should be detached		Part II. Other significant conditions con	tributing to death but not resulting i	in the underlying cause giv	ven in Part I.		co use contribute to	the cause of death?						
Division of Vital Records,	The law requi	Completed by					24a. Was an autopsy performed 1 🗆 Yes 2	prior to condeath?	opsy findings available completion of cause of						
ita	ysician: The is certificate I director, pag	Be c	25. Was case referred to medical examiner?	ospital:	Oth	ace of Death (Check	-								
of V	ing Phys	ate: To	27. Manner of Death  1 Natural 5 Pending		Time of 28c. Injury	y at	28d. Describe how in	e 6 Other (Specifing occurred)	y)						
ivisior	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completed filled in by the funer	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)			28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,						
Ω	Hospital 24 hours Funeral eted filled	Medical	(Check 2 Medical Examination	cian: To the best of my knowledge, er: On the basis of examination and/o Practioner: To the best of my know	or investigation, in my opinio	on, death occurred at	t the time, date and pl	lace, and due to the ca	ause(s) and manner stated.						
	To the within To the compl	Σ	only one) 3 Certifying Nurse 29b. Signature and title of certifier	M. WALL	29c. License			Date signed (Month,							
	5pm		30. Name and address of person who co	mpleted cause of death (Item 23a) (	(Type, Print)	icuThi A	RIVI. /	THE WAS	M) 1000						
	Sta Registr		31. Date filed (Month, Day, Year) <b>AUG 1 4 2012</b>	32. Registrar's Signature	ared	9									

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Terri Tuck State of Maryland / Department of Health and Mental Hygiene 2012 25863 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle Last) 2. Date of Death Terry Marie Tuck 3. Time of Death Month Medical Examiner 1417 hrs August 9, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Raltimore 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Country) Mi 217.78.153 1 M Yrs Usual Residence of Decedent any 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD 1 es 2 No altimore with the Maryland Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3511 7A USA 21213 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Married Yes 1 Yes specify: If Yes, Give Yaar or Dates: Pages 1 and 2 should be filed within 72 hours after 4 Divorced BIACK Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Indust Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 PRIVATE HomeMaxer and Mental Hygiene Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ment of Health and Mental H tant: If item 27 is marked or other traumatic event, t Be 2NAdine 19a, Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zoa. Method of Disposition PARKLAWN Avenue BAHMORE, MD ZIZIZ HART 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place Burial 2 Cremation 3 Removal from State DAltimore Redeemer Holu Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility VAUGHO C. Cereene Tunenal 4905 York Road Battimure, Maryland ZIZIZ Physician Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Methadone and Cocaine Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and Physician/Medical  $\times$  AMENDED #1,23a,27,28a-f, per me,g931 9-5-12 SM X UNPENDED signed by the attending physician I be detached for use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, ficate has been si, , page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? After this certificate Yes 2 No 2 No 1 Yes within 24 hours after deam.

To the Funeral Director. After this certific 25. Was case referred to medical 26 Place of Death (Check only one) å examiner? Hospital: 1 \_\_ Inpatient 2 ✔ ER/Outpatient 3 \_\_ DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Certification Pending 1 Yes 2 X No subject used drugs fd 8-9-12 fd 13:33 pm 2 X Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)  $2401\ Belair\ Rd.$  Baltimore, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be (Specify) Convenience Store 4 Homicide determined 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 10, 2012 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PRY 20°°2 4:55 A M Mary Elizabeth Thornton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery ManorCare Bethesda Bethesda . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 F Months Days Hours CONTEW York (Merth 04 1949 250-92-5197 63 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director Yes 2 No MD Unkn Unkn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA Unkn 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 9 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify. Completed 3 Widowed 4 X Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Me College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leon Powers Mary Thornton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6209 Lone Oak Drive, Bethesda, MD 20817 Leila F. Search / Daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Crematory 8/11/2012 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death
UNKNOW' Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a od Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? for Month Pregnant at time of death 1 ☐ Yes 2 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Hospital 1 Tes 2 🗶 No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Inpatient 2 🗆 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director:

Completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D43121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar CHOWDHURY

32. Registrar's

605 Main St, Laurel, MD 20707

26 Per WERBand 30 Solatiment of Health and Mental Hygiene For State Registrar 25865 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 36 AM Physician/ ho 2012 Medical 4a. Facility Name (if not institution, give street and tumb 4b. City, Town, or Location of Death 4c. County of Death **Examiner** toho 10h 8 7. Age (In yrs. last birthday) 76 Yrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-34-9984 Months Hours Min. Country) MD 0/81/12/3·/11/933 Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director MD Baltimore 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 521 North Glover Street with 1 21224 USA permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: If Yes, Give 3X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Housekeeping 12 Be 18. Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) UNK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Powell 521 North Glover Street Baltimore MD 21224 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Atlantic Crem 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 07/29/12 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simplicity neral Service Licer Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Ener Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death signed by the at d be detached fo g Unknown Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown plnous peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy page 2 this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: After 4 28d. Describe how injury occurred iniury Natural 5 Pending 2 🗌 No Accident Investigation 24 hours after death Funeral Director: filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the f only one 29b. Signa than woods And Ballimore MD 21234 AUG 0 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

K

DHMH 17 Rev 7/2009

	-	For State Registrar	State of M		d / Depa		of He	ealth a		lental Hy		e 2 N	1 2	25868	5
Physicia Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  Norman Thomas  2. Date of Death  Month  8-95								S County	Year of Death	3. Time of Death			
Funeral	iei	Joseph Ritchie Hospice Baltimore									N/A		ace (State or Foreign	_	
Director		5. Social Security Number 2 13-64-3822  Usual Residence of Decedent			56 Yrs. Months Days Hours Min.								Counti	y)	
//daryland 8a-f shor	rector	10a. State 10b. Count N	A A		timor timor							10d. Inside City Limits X 1 □ Yes 2 □ No			
with the {	Funeral Director	10e. Street and Number 500 Roundvie	w Road			1 /1//5							Citizen of What Country?		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Importment of Health end Mental Hygiene. Important: If them 271s marked other than "netural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantuer must be notified at once.		11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 X Divorce	Ever in U.S ? ] No		Was Deceder f Yes, specify	y Cuban,		n, Puerto F				e - America k, White, e Blac	nerican Indian, nite, etc. Lack		
Maryland 21215-0036 2 should be filed within 72 hours efter th end Mental Hygiene. 27 Is marked other than "netural", o traumatic event, the Medical Exam	Completed by		15. Decedent's Education (Specify only highest grade completed)  lementary/Secondary (0-12)  1 2 th  N/A			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Store Manager							16b. Kind of Business/Industry Game and Tack Store		
yland Id be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Norman G.		<u>.</u>						(First, Middle, Pledg		n Surname,	)		
hy Mar nd 2 shou ealth end m 27 Is m		19a. Informant's Name/Relation Darren Bell/	ship (Type, Print) Son		19b. Mailir 611	Brid	gevi	d Numbe Lew	er or Rural Rd •	Route Number #A Ba	er, City o	or Town, St		ode) 21225	
Baltimore, pemit. Page 1 and Department of Hea Important: If them any Injury or other once.	JC - 51	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		e Met	lace of Dispo emetery, crer LIO CI	remat remat	er place, Ory		8/1	<sup>ate</sup> 7/12	Ca		vill	e, MD	
Balt permit. Departimort any inj once.		21. Signature of Funeral Service	Licensee		22.	Name and P	Address dmoi	of Facilit ndsc	yBevo n A	erly I ve. Ba	ilto	Croma	arti MD 2	e F/S 1223	
Physician/ Medical Examiner	iner	23. Part Enter the disease, the condition of the cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as	ne.  Weta s a consequ	O STATE	ar the mode of	dlu	Such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death	
\$\int \frac{\gamma}{\gamma}\$ (100) rate be executed a physician and as the burial-transit	ledical Examiner	Caruse [Usease or injury that initiated events resulting in death) Last	ence of):	νή:											
Division of Vital Records, P.O. Box 6876C Hospital or Attending Physician: The lew requires that the death certificate 14 hours after death. Funeral Director: After this certificate has been signed by the ettending physically filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1  Live Birth 4  Pregnant 9  Unknown	2 Feta at time of c	death 3	Ectopic pro Other (spec						23d. Dat Mor	e of delive	ry Day Year	
S, P.O.	d by Ph	Part II. Other significant condit	tions contributing to death	but not res	ulting in the u	inderlying ca	use give	n in Part	l.	23e. Did 1		_1		e cause of death?	_
Records, The lew requires are has been sig	Completed by									24a. Was	an psy ormed?	24b. V	Vere autop	sy findings available apletion of cause of	
Vital   hysiclan: his certific	To Be	25. Was case referred to medica examiner?  1  Yes 2 No	Hospital:	itient 2 🗆	ER/Outpatie	nt 3 □ DOA	Other		ith <i>(Check</i> ursing Hor	on <i>ly one)</i> me 5 ☐ Resi	idence	6√⊈ Othe	r (Specify)	Honoice	_
Division of Biological Plants and a feet death.	Certificate:	27. Manner of Death  1 Natural 5 Penc 2 Accident Inves 3 Suicide 6 Coul	stigation	jury ay, Year)	28b. Time of injury	280 M	c. Injury a work? 1 🗆 Y	at ′es 2.⊑		28d. Describe	how inju	injury occurred			
Division of Vital Recc To the Hospital or Attending Physician: The lew within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	ai Cert	4 ☐ Homicide deter	mined 28e. Place of Ir building, e	tc. (Specify	)	,				City or To	wn, Sta	te)		Route Number,	3
To the Hosp within 24 hos To the Fune	Medicai	(Check 2 ☐ <b>Medical</b> only one) 3 ☐ <b>Certifyi</b> r	ng Physician: To the best of I Examiner: On the basis of ng Nurse Practitioner: To the control of the control	examination	and/or inves	tigation, in m	y opinion red at the	, death or e time, da	ccurred at	the time, date :	and place the cau	ce, and due se(s) and m	to the cau anner as st	se(s) and manner state ated.	d.
5 × 5 0 0		29b. Signature and title of certifi	hr.				License i	number 1064	126		29d. D	Date signed	(Month, D	lay, Year)	
21		30. Name and address of person	lacen Certain	FBLOW	4 6	Print)	ind	unA	V B	ally Ma	0 . 3	1901			_
Sta Registr	ar	31. Date filed (Month, Day, Year)	4 2012	har's Signat	A. A	all	Ī					w w -			_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 20/Z 11:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner harles 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year) Director 1 XM 2 □ F ruerto-28e-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code ö 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Puerto Rican 1 X Yes 2 ☐ No Specify: If Yes, Give / Year or Dates. Completed 3 Widowed 4 ☐ Divorced 27 is marked other than "netu r traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ndary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ၉ 19a. Informant's Name/Relationship Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to once. Lane 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility 21202 Sa. Part 1. Emili the disease, or complications that call as shock, or heart failure. List only one cauling on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death liate Cause (Final Physician/ or condition ulting in death) oron Medical Examiner Sequentially list conditions, if any, leading to immediate the Fifter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Medical Certificate: To Be Completed by Physician/Medical Exami resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X N 2 🗌 No 1 🗌 Yes 1 Tyes completely filled in by the funeral director, 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Hospitel or Attending Pi 24 hours after deeth.Funerel Director; After the 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospitel within 24 hours a To the Funerel E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature august 10; 20/2 43276 ddress of person who completed cause of death (Item 23a) (Type, Print) 20772 Ospon du 106 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ tugust 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Baltimore C Baltimore HOSPITAL GOOD SAMARITAN Social Security Number Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** Hours 05/23/ Maryland 218-60-8658 Director 60 Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21234 6847 Sturbridge Drive USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Self Employed 11th grade College (1-4 or 5+) CNA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Johnson Beatrice Whye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6847 Sturbridge Drive #D Baltimore MD.21234 Muriel Whye/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Bayview Crematory 8/20/12 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Dundalk Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service License 5240 Reisterstown Rd.Baltimore MD.21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK Prysician/ disease or condition Medical resulting in death) Examiner NEU MONI Sequentially list conditions, Examiner Tay, leading to immedia cause. Enter Underlying Cause (Disease or iinjury LIVER CANCER use as the burial-transit METASTATEC · Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician Certificate; To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day ō Month Year Pregnant at time of death 9 Unknown q Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed None 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 1 Yes 2 No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) director, examiner? 1 ☐ Yes 2 ☑ No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pendina s after death.

I Director: Aff 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated within 24 hou

To the Fune

completed fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

5601 Loch Raven Boulevard Baltimore, MD 21239

ne and address of person who completed cause of death (Item 23a) (Type, Print)

Hicks III MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ Month Arbry Lee Walton 0014 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore imora Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Min. Hours Virgiia 225-26-0858 Director 1 🖾 M 2 🗆 F March 23,1922 Usual Residence of Decedent 10a, State 10b. County rel", or items 23e or 28e-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore N/A Maryland YE Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. Funeral 21216 2725 Walbrook Avenue USA 12. Was Decedent Ever in U.S. Argied Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Black þ Never Married 2 Married 21215-0036 1 Yes 2 No Specify: "naturel" Completed Specify 3 Divorced 4 Divorced Year or Dates Page 1 end 2 should be filed within 72 hour ment of Health end Mentel Hygiene. ant: If item 27 is marked other then "naturury or other treumetic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 4th grade College (1-4 or 5+) Steel Mill Steel Workér Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (*Eirst, Middle, Maiden Surname*) Eunic∈ Oren Willie Walton 19a Informant's Name/Relationship (Type, Print)
Shireena Henderson / Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7949 Bayard Drive Hummelstown, PA 17036 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20b. Place of Disposition (Name of cemetery, crematory or other place) 8/17<sup>949</sup>12
Poplar Mount Baptist Ch. Cem 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State . Lawrenceville, Va 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facilin Chatman-Harris Funeral Home 5240 Reisterstöwn Road Baltimore MD 2121 21. Signature of Funeral Service Licenses Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Patrent Interval Between Onset and Death Immediate Cause (Final Physician/ usease Medical resulting in death) CENTRICATION APPROVED BY METHON CHAP Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physicien: The lew requires that the deeth certificate be executed the ettending physician and ched for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate 1 Yes 2 No 1 Yes 2 No the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Atatural 2 Accident 3 Suicide To the Hospitei or Attending within 24 hours after death.
To the Funerel Director: Afte completely filled in by the fun 5 Pending injury UnknownM 36 2012 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2025 Wal Drook Ave, 21211 4 Homicide tome Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce R14899 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ren h 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 Registrar 4

ORIGINAL

DHMH 17 Rev 06-2011

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AMEND ITEM#5, 11perFH, G930, 8/17/2012, WS
State of Maryland / Department of Health and Mental Hygiene 25870 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August David Elliott White 2012 4:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac Valley Nursing Center Rockville Social Security Number 3626 . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** Days 1 ▼ M 2 □ F Months Hours Min. New Hampshire 67 1944 Director Oct. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland at Director notified 1 X Yes 2 □ No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral 20817 United States 6530 Democracy Blvd. items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter edical Examiner med Forces Black, White, etc. 1 Never Married 2 Married XXYes þ Maryland 21215-0036 within 72 hours after 1 Yes 2XXNo Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates. 1968-94 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. Elementary/Seconday (0-12) College (1-4 or 5+) Business Manager Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eleanor Hickey White Dorothy David Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Ranworth Ct., Germantown, MD Richard A. White / Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Uniformed Sers. Univ. 08/08/2012 4 Donation 5 Other (Specify) Bethesda, MD M00382 Rapp Funeral and Cremation Services 20910 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner **EMPHY SEMA** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trai or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) Pregnant at time of death ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to \$ 2 No 3 Probably XX Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No certificate Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4XXNursing Home 5 - Residence 6 - Other (Specify) 2 XNo ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 24 hours after death.
Funeral Director: After thieted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending 1 Yes 2 🗌 No \_\_ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completed filled in the Hospital Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D42518 AUGUST 8, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20852 11119 ROCKVILLE PIKE, #401, ROCKVILLE, MD GUL G. CHABLANI M.D., 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2587 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Year Physician/ AUGUST WOOD SELMA Α. 10:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY SILVER SPRING 13118 WILTON OAKS DRIVE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Hours Months Director 579-54-3027 72 1 □ M 2 🛛 F WASHINGTON, DC MAY 23 1940 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location with the Maryland at Director notified 1 X Yes 2 No SILVER SPRING 28a-f MD MONTGOMERY 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö pe ms 23a o must be Funeral 20910 USA 13118 WILTON OAKS DRIVE items ; death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S ian "natural", or ite Medical Examiner Armed Forces Black, White, etc þ 1 X Never Married 2 Married Yes 2 No 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X☐ No Specify. BLACK Specify If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates. 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) the Me Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygiene is marked other the raumatic event, the DAY CARE PROVIDER PRIVATE 12**t**h Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 GERTHA BONNER DEWEY WOOD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. FRANCES LOGAN/SISTER ST JOHNS PL UPPER MARLBORO, MD 20774 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEM CEMETERY: 08/15/2012 LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature Funeral Service Lice 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between 10 YRS Immediate Cause (Final Physician/ CARDIOVASCULAR DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be execut d Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Vear Month 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BREAST CANCER 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛚 No Certificate: To 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🗌 Yes 2 🗎 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After to completely filled in by the funer iniury 5  $\square$  Pending 1 X Natural Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29h. AUGUST 6, 2012 254378

State Registrar

DHMH 17 Rev 06-2011

2730 UNIVERSITY BLVD WEST #400 WHEATON, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHERYL ELLSWORTH MD

AUG

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST Physician/ Harold S. Wulforst 2012 4:51 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 132-10-5202 **Director** 1 XM 2 - F 93 5/18/1919 New York Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10c. City, Town or Location 10d, Inside City Limits Director Maryland **Baltimore** Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21204 U.S.A. Chestnut Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) WUIFORST, MAROI Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' 1 Never Married 2 X Married 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Postal Service Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lila Southard Wulforst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter H. Wulforst / Son 3090 Laverne Court Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other page 200). 20a. Method of Disposition 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory of Crest Lawn Mem. Gar. 8/18/2012 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Myocardia Physician/ disease or condition Medical resulting in death) Due to (or a a consequence of Examiner (Oronaun Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5  $\square$  Pending after death.

Director: Af 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours after Funeral Direct letely filled in b Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 ho
To the Fune (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Evertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29d. Date signed (Month, Day, Year) th (Item 23e) (Type, Print). Charles St. Bal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Registrar

AUG 1 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 8 Physician/ e Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Care Center Baltimore Baltimore if Under 1 Year If Under 24 Hrs.

Manage Parks | Davs | Hours | Min. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 129-07-1989 **Director** 1 M 2 K F 93 Oct. 08, 1918 New York 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shorany injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Baltimore Baltimore MD. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 8830 Walther Blvd. #323 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specif White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department Store Sales Associate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stephen J. Loughman Hannah Driscoll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1253 Dockside Circle Baltimore, MD. 21224 John Scott Wilfong/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 8-16-12 Timonium, MD. Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig ature of 22. Novel A Towson Tuneral Home, 1050 York Rd. Towson, md. eral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ MINUTE disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death
Unknown Month Day Year Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No of a free death.

Director: After this certificate h 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 1 🕰 Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VICTORIA VANIK MO 8200 WQL/Hor BIVD Balt more 31. Date filed (Month, Day, Year)

Registrar

(X)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 0 3 Month 6 Year Physician Helen Wallace 4 YEA M 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1552 Waverly Way N/A Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Months 1 ☐ M 2 🗶 F 219-32-4021 78 Director 5/3/1934 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ¥Yes 2 No N/A Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with and Mental Hygiene.
Is marked other than "natural", or Items 23a or ? 1552 Waverly Wav 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 9th N/A Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Martha Holley George Holton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 77 Is m any Injury or other Karen Sims-Daughter 1552 Waverly Way Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State King Memorial Pk. 8/8/2012 Randallstown, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East 1101 E. North Ave. Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. frogsence Dechne Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of): Physician/Medical Examiner Demente burial-tra The law requires that the death certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Drabeta the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown ate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Rhematord Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Jont 24a. Was an Diseans performed? 1☐ Yes 2☐ No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 No 1 TYes Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 VertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hor To the Fune completely fi

State Registrar

29b. Signature and title of certifier

821 N. ENTAWST Shite 308 HASIAMI MD. A. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

MD

29c. License number

P31464

29d. Date signed (Month, Day, Year)

BALTIMOLF MD 21211

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 PM Physician/ 3.06 201 Williams Audrey Lee Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Rosedale quare If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** Security Number Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 07-21-1945 Days Hours 146-36-5970 67 **Director** 1 M 2 X F 28a-f show 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ms 23a or 28a-f s must be notified Rosedale Baltimore Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21237 8206 Analee Avenue items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iter Black, White, etc þ 1 Never Married 2 Married within 72 hours after 21215-0036 Black 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 X Divorced Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than matic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha Health Care Private Duty Nurse Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Bedfearn Fred Williams 둫 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 8206 Analee Avenue Baltimore, MD 21237 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau Tracey M. White - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State Gardens of Faith Cem. 08-10-2012 Baltimore, Maryland 4 Dopation 5 Other (Specify) 5305 Harford Road Baltimore, MD 21214 Funera/Service-Licensee 21. Sional re 22. Name and Address of Facility Leonard J. Ruck, Inc. 23a. Part 1. Exter the disease, or complications that caused shock, or heart failure. List only one cause on each line. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Atherosc Medical **Examiner** Sequentially list conditions, if any leading limit in the cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events burial-tr Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the k IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 No 9 Unknown for Month Pregnant at time of death ed by the a detached 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 MNO ပ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending 24 hours after death Funeral Director: A Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) MD 08/05/2013 D0061662 MEL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan sanklin Square Drive Baltimore

State Registrar Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 4 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1.56 AM Rosetta Ward Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death SINAI HOSPITAL BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 213-28-4198 **Director** 1 🗆 M 2 🕉 F 05 10 26 VA 86 Usual Residence of Decedent Show 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director or items 23a or 28a-f MD NA Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3915 Annellen Road 21215 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 X Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 6th grade Homemaker House nā 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Holden Ward Sr. Mildred Clayborne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3915 Annellen Road, Baltimore, Md 21215 27 Shawn Ward Dunlap-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 8/17/2012 | Arbutus. Md Memorial 21. Sig styre of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that eadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ARRH YTHMIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? ō 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 ed by the a 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown CONGESTIVE HEART PAILUKE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 1 Yes 2 🗌 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 4 \( \to \) Nursing Home 5 \( \to \) Residence 6 \( \to \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred A Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL OF BALTIMORE WILLIAM 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Rosetta

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			Registrar  1. Decedent's Name	Decedent's Name (First, Middle, Last)  2. Date of Death 3. Time of Death													
	Physicia		DECON SITE TANKS										Month Day Year August 08 2012 2:15p				
1	Medi Examir		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death								of Death	magaz	4c. Count	y of Death			
1			Greater Baltimore Medical Center Towson										Ва	ltimo	ore		
	Funeral		5. Social Security Nu		Sex	7. Age (In yrs.	last birthday)	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birl (Month, Da		9. Birthi Coun	olace (State or Foreign try)		
	Director		214-36-93 Usual Residence o		1 □ M 2 😿 F	72	Yrs.					JULY 3		MARY	LAND		
	and show	ē	10a. State	10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limits		
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	th the	Funeral Director	10e. Street and Num					10f. Zip 0	Code				10g. Citizen of	What Cour	ntry?		
_	ith wii ms 2 must	ner		LVER LAI		E cedent Ever in U.	c [12.1		2112		-:-0 (0	f .	USA				
(0	er dea or ite niner	by Fi	<ul><li>11. Marital Status</li><li>1 ☐ Never Marrie</li></ul>	ed 2 🔀 Married	Armed F			f Yes, specify	y Cuban	, Mexican	gin / (Speci n, Puerto Ri	fy Yes or No- can, etc.)		ce - Americ ick, White,			
93	rs afte iral", Exar	ed b	3 Widowed 4		If Yes, G Year or I	iive	1	1 ☐ Yes 2	<b>X</b> No	Specify:			Specif	y: <b>W</b>	WHITE		
21215-0036	72 hours after death with the Maryland n "natural", or Items 23a or 28a-f sho dedical Examiner must be notified at	Completed	(Spec	15. Decedent's cify only highest of		d)		lent's Usual kind of work			t of working	Y	16b. Kind of I	Business/In	dustry		
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	and 2 s Health a tem 27 i		WILLIAM		S SR.	SPOUSE	8611	SILVE	ER L	AKE I	DRIVE	PERR	Y HALL,	MD.	21128		
Baltimore,	~ 0 4- 1-		20a. Method of Disp 1 👿 Burial 2	osition ☐ Cremation 3 l	Removal from		Place of Disponentery, cren			,	Da	te	20c. Location	- City or To	wn, State		
tim	it. Pag rtmen rtant: njury		4 Donation	5 Other (Spec	cify)	CA	MP CHA				8-11-	-2012	PERRY	HALL,	MD.		
Bal	permit. Page 1 s Department of F Important: If ite any injury or ot		21. Signature of Fun	eral Service Lise	nsee 6	_	22	Name and <b>705 BE</b>	Address	of Facilit			FUNERA				
			23a. Part 1 Enter th	ne disease, or con	mplications that	caused the deat							HAM, MD rest,	. 212	Approximate		
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Medical			resulting in death)		a. Due to	o (or as a conseq	delice oi).			170	Cy.	1001	1000				
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x 687	endin r use	an/l	IF FEMALE: 23b. Was decedent p			utcome of pregna		Ectopic pre	egnancy	23d. Date of					ery		
Вох	death	Physician/Me	in the past 12 m 1 ☐ Yes 2 <b>2</b> 9 ☐ Unknown	No		gnant at time of		Other (spec				Month Day Ye					
P.O.	The law requires that the death certifica ate has been signed by the attending pipage 2 should be detached for use as t		Part II. Other signific	cant conditions	contributing to	death but not res	sulting in the u	nderlying ca	use give	n in Part I	l.	23e Did to	hacco use con	tribute to th	e cause of death?		
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ord	requ been shoul	lete										24a. Was a	an 24b.	Were autor	osy findings available		
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of	ding Pl fh. After th funeral		27. Manner of Death 1 Natural	5 Pending		e of injury nth, Day, Year)	28b. Time of injury	280	. Injury a work?	at	28	d. Describe h	ow injury occur	red			
ion	ttendi death. tor: A r the f	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not	he -			М		es 2 🗆	_						
Division of Vital Records,	l or At after Direc	Cer	4 Homicide	determined	d 28e. Plac build	e of Injury - At he ding, etc. (Specify	ome, farm, stre	et, factory, o	office		28		ion (Street and Number or Rural Route Number, r Town, State)				
Ω	To the Hospital or Attending Physiciam: whith 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	ical	29a. Certifier 1	Certifying Ph	ysician: To the	best of my know	ledge, death o	occurred at the	ne time,	date and	place, and	due to the ca	use(s) and man	ner as state	ed.		
	he Ho in 24 l he Fu ipletel	Medical	(Check 2	Medical Exar	niner: On the ba	asis of examinatio er: To the best of r	n and/or investi	igation, in my	opinion,	, death oc	curred at th	e time, date ar	nd place, and du	e to the cau	ise(s) and manner stated		
	North With Con		29b. Signature and ti	tle of certifier	2		·	29c. L	icense r	number	776	~	29d. Date signe	d (Month, L	Day, Year)		
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	MON		30. Name and address	ss of person who	completed cal	use of death (Item	1 23a) (Type, P	rint)	110	1 0	TEC-	ON TO	ne neco-	7 11	21204		
	Sta	130. Name and address of person who completed gause of death (Item 23g) (Type, Print)  William Schull A. (6535 N Cinvily St. STESSO TOWSON, M.  State. 31. Date filed (Month, Day, Year)  32. figistra's Signature.									121						
^	Registra		/	AUG 14	2012	neur	1. S.	and									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ AUGUST LENA M. WILLINGHAM 5:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SHINING MOON ASSISTED LIVING TOWSON BALTO. If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months (Month, Day, Year) Director 218-01-4168 1 □ M 2**X**□ F 96 Yrs. JULY 6,1916 MARYLAND 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Examiner must be notified at Director MD. BALTO. NOTTINGHAM 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 22 WHIPS LANE 21236 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 6 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE Specify "natural" 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hyglene. 27 is marked other than r traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) 8TH HOMEMAKER HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 SALVATORE BRUNO MARIA PITTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. t of Health MARIA M. JOHNSTON 22 WHIPS LANE NOTTINGHAM, MD. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of
Importent: If it
any injury or o 1 Removal from State 8-9-2012 4 ☐ Donation 5 ☐ Other (Specify) MOST HOLY REDEEMER BALTO.MD. SCHIMUNEK FUNERAL HOME, INC. Signature of Funeral S 22. Name and Address of Facility 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ , abl disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death this certificate has been signed by the ral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes No 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 2/No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospitel within 24 hours a To the Funeral C completely filled the Hospitel Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

Registrar DHMH 17 Rev 06-2011

State

29b. Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August Physician/ 2012 6:45 AM Joseph George Weiner Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days (Month. Day, Year, Hours 110-05-2000 Director 1 X M 2 □ F August 15, 1915 96 Yrs New York Usual Residence of Deceden 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b County Director 1 X Yes 2 No Washington D.C. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20037 United States 1099 22nd Street, NW, #805 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married by 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 1946 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Lawyer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mary Kosciesky Gedalia Weiner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1099 22nd Street, NW, #805, Washington, D.C. 20037 Winifred E. Weiner / Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition August 13. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 20I2 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune ture of Fune / Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Muemonia Preysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) al or Attending Physician: The law requires that the death certificate be executed safter death.

I Director, After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Other (specify) cate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 5 Pending 1 📐 Natural Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral I Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) the of certifie 29b. Signature 13 2012 1)006 (30 30. Name and add s of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Atul Rohatgi, MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0 Pay Physician/ 08 donth 2072 9:45A LaNita Danite Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co Seasons Windsor Mill Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) 03/06/1972 Days Hours Country 212-88-4952 **Director** 1 M 2 XF 40 Maryland 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director tx☐ Yes 2 ☐ No Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 2235 Reisterstown Rd. 21217 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc. þ δ 1 X Never Married 2 I Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: Black 3 Nidowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. 1 0th Grade College (1-4 or 5+) Food Services Phillips Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F and Mental မ Sheldon Williams Betty Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Betty Smith (Mother) 2235 Reisterstown Rd., Baltimore, MD 21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park 08/11/12 Baltimore, 21. Signature of Funeral Service Licenses 305€ph<sup>Ad</sup>#°SEfedWn Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cerebella Physician/ Neurodezene atthe 64 W Medical resulting in death) Due to (or as a conjuence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami signed by the attending physician and deedetached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown After this certificate has been significate has been significated and a should a sho 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 🗌 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) hospke examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 I DOA To the Hospital or Attending Physical 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 4,2012 031513 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Box MD 21800 A0 Salisburg Cibell WD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 5 per FH, G930, 8/17/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08/06/2012 Henriette Fernande Zbiegniewicz 5:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Alfred House II 9. Birthplace (State or Foreign Country) France Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days (Month, Day, Year) 03/16/1927 1 □ M 2 💢 F Hours 85 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director notified MD Montgomery Silver Spring 1 Tes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō "natural", or items 23a or Funeral 20910 United States 810 Silver Spring Ave. hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "n 72 Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Emile Henri Stillierre Denise Jeanne Noemi Peruisset or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra 810 Silver Spring Ave. Silver Spring MD 20910 Karine Zbiegniewicz-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Arlington National Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington VA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility 933 Gist Ave. 2091 Rapp Funeral & Cremation Ser. 10000 AO Silver Spring MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Dehydration disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Inanition Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate Dementia and I-transit Cause (Disease or linjury that initiated events resulting in death) Last ending physician ar use as the burial-to Due to (or as a consequence of): Alzheimer's Disease Physician/Medical P.O. Box 68760 d IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? atter for L Month Year Day Pregnant at time of death 5 Other (specify) isigned by the a 9 Unknown 9 Unknown law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, s been signated by should by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy perform certificate Yes 2 No 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 455554CD Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After t Attending 5 Pending 1 Natural 1 Yes 2 No Accident
Suicide or Attend after death Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aff To the Funeral Di completed filled in the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Olu MA 25410 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Oliver J. Lawless 18111 Prince Phillip Dr. Olney MD 20832 0 Oliver J. Lawless 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #20b per FD AACO Health Dept. 7-31-12 KAH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death <sup>Day</sup>012 Physician/  $J_{uly}^{Month}$ 26, 6:07 A MEulah Adams Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 407-22-9000 Director 1 □ M 2 🛣 F 10/15/1926 KY 85 Usual Residence of Decede 28a-f shov 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at 10a State 10b. County 10d Inside City Limits Director MD Baltimore Timonium 1 Yes 2 X No A.M. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with t 1818 Blakefield Cir. 21093 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo injury or other traumatic event, the Medical Examiner Black. White, etc. or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: "natural", Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working should be filed within 72 land Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Denzil Ratliff Lucy Walker JULY 26, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s.
Department of Health a
Important: If item 27 is
any injury or cet. 1818 Blakefield Cir Timonium, MD 21093 Gary Adams (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 7/28/12<sup>ate</sup> cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State Lakemont MEm. Gardens 5/28/2012 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home 12 Ridgely Ave. Annapolis, MD 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ eu monio n disease or condition resulting in death) Medical consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examir trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 22 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ADAMS 24a. Was an has autopsy performed? Yes 2 N After this certificate 2 (No 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1🔀 Natural 5 Pending work 1 🗌 Yes 2 🗌 No eral Director: A filled in by the fi Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Till Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier License number 6m 2012 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 21093 TIMONIUM MD2300 DULANEY VALLEY ROAD ERNESTINE WRIGHT, M.D. 3 1 2012 31. Date filed (Month. 32. Registrar's Signature State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death August 20T2 2245 Nick Arches 4c. County of Death 4b. City, Town, or Location of Death Ceci1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Davs 1 🕅 M 2 🗆 F Months Hours SEPT 8, Year 930 New York 81 10b. County 10c. City, Town or Location Ceci1 E1kton 10f. Zip Code 10g, Citizen of What Country? 21921 United States 14. Race - American Indian.

For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Ρм Medical 4a. Facility Name (if not institution, give street and number) Examiner 25 Park Lane Social Security Number 9. Birthplace (State or Foreign Funeral 216-28-7151 Director Usual Residence of Decedent 10d. Inside City Limits 10a State with the Maryland Director notified 28a-f 1 Yes 2 X No Maryland ms 23a or r must be n 10e. Street and Number Funeral 25 Park Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1952-1 X Yes 2 No 105 permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important if item 27 is marked other there is any injury or other traumant. 11 Marital Status ρ 1 Never Married 2 Married 1955 1 Yes 2 X No Specify. Specify: White If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Automobile Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Millwright Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Hazel Ann Brown Louie E. Arches 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 493 Pond Neck Road, Earleville, MD Diane L. Jones/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Gilpin Manor Memorial Park 1 X Burial 2 Cremation 3 Removal from State 2012 Elkton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signati e of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transil that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as tl IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No าสร is certificate ha 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending death. Investigation 6 Could not be Director: / Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number pleted cause of death (Item 23a) (Type, Print) 1 main Cot (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2<u>012</u> Physician/ Month Sarah A. Bartgis 25 12:42 P M Medical Ju<sub>1</sub>v 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Northampton Manor Frederick 5. Social Security Numbe Funeral 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) Min. Months Hours (Month, Day, Year) 578-44-5202 Director 1 🗆 M 2 🐴 F Yrs. 86 Oct.26,1925 Indiana 28a-f show permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Importent: If item 27 is marked other then "neture!", or items 23a or 28a-f sho eny injury or other traumatic event, the Medical Example and the Alboratory injury or other traumatic event, the Medical Example 7. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick 1 X Yes 2 No Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21702 1691 Shookstown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black. White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 XWidowed 4 Divorced Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Data Entry Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Carroll Wallace Kent Fern Hanway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1691 Shookstown Rd., Frederick, MD 21702 Deborah Bartgis / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 St Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/30/2012 Clustered Spires Frederick, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure List only one cause on each line. Onset and Death Immediate Cause (Final DEREMTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death
9 Unknown Month is certificate has been signed by the a director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 2 No ဂ္ 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined ca 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medic Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 1006 LL 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAYEON BOANUM, 196 TTDLLVE, PLE 96 TTOLIVE, FLET ENCK, MD 21702 31. Date filed (Month, Day, Year)

Registrar

State

32. Registrar's Signature

2012

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Wayne Bowie 4:15P ul Medical County of Death 4a Exility Name (if not institution give street and number Examiner HARLES IVISTA Social Security Number Birthplace (State or Forei Country) 7. Age (In yrs. last birthday) If Unde 8. Date of Birth **Funeral** Min (Month, Day, Year) 6/17/1940 72 216-40-5551 Director 1**X** M 2 □ F MD Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limi Director must be notified Waldorf 1 X Yes 2 □ Charles MD 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20602 USA 1110 Hamlin Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 5 þ 1 Never Married 2 Married ☐ Yes Yes, Give 2 🔀 No White 1 ☐ Yes 2X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) giene. Elementary/Secondary (0-12) College (1-4 or 5+) the Painter Private Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) ပ Jennie Bowie Richard N. Bowie and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Carolyn Bowie/Wife 1110 Hamlin RD Waldorf, MD 20602 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Mem. Cem. 8/2/2012 Waldorf, MD Trinity uge of Funeral Service Licer 22. Name and Address of Facility Briscoe-Tonic Funeral Hom Samuely C/DUSCOC-10nic MD 2060 2294 Old Washington RD Waldorf, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final tovancião. Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No į Month Day Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unkno Completed 24b. Were autopsy findings availab prior to completion of cause of death? 24a. Was an has perform 2 🗌 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 XNO To E Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Director: After 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No filled in by the Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined within 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar DHMH 17 Rev 06-2011 rembrooke

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 1:05 Рм July Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Linthicum Tate Hospice House Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8. Date of Birth June 8, 1934 216-30-0024 Days 78 Director 1 🔀 M 2 🗆 F Yrs th and Mental Hygiene. 27 is marked other than "naturel", or Items 23a or 28a-f show traumetic event, tre Medical Evaniar must be notified at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis 1 ☐ Yes 2XXNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 3134 Starboard Drive 21403 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2554No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married ፩ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Entrepreneur Moving Company 12 Be 17. Father's Name (First, Middle, Last) Should be file and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Hall Fritz J. Bjorntvedt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3134 Starboard Drive Annapolis, Maryland permit. Page 1 and 2 sh Department of Health ar Importent: If item 27 is eny Injury or other trau once. Audrey Bjorntwedt/wife 21403 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Hillcrest Mem. Gardens 7/31/2012 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Maryland 21. Signature of Tuneral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): igned by the attending physician and be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Yes Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? ျှ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of rson who completed cause of death (Item 23a) (Type, Print) 6 31. Date filed (Month, Day, Year) State 30 Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

JUL 3 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard Barnes 19 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbur Wicomico Funeral Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 134-28-0654 Months (Month, Day, Year) 1-30-1936 New York Director 1 X M 2 D F Usual Residence of Deced I Hygiene. I other than "natural", or items 23e or 28e-1 sucovent, the Wedical Evarient must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo DE Sussex Seaford 1 Yes 24 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 Big Mill Branch 19973 HSA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 ☐ N/o Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Parts Associate Mechanical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Barnes should be file and Mental F 1 end 2 should be file of Health and Mental F Item 27 Is marked o Unknown ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen E. Barnes 11 Big Mill Branch Seaford, De. 19973 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 e 20c. Location - City or Town, State ō <u>-</u> Injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Important: It any Injury or First State Cremation 7-19-2012 Millsboro, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West St. Hannigan, Short, Disharoon F.H. Laurel, De. 19956 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Cause (Disease or injury that initiated events resulting in death) Last nding physician end use as the burlel-tran Due to (or as a consequence of): Physician/Medical Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year ed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed d be def 23e. Did tobacco use contribute to the cause of death? ۵ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificete funeral director, pag 3-11 2 No ☐ Yes 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) ည 1 Yes Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural
2 Accident 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier frank who completed cause of death (Item 23a) (Type, Print) 6 00 31. Date filed (Month, Day, Year) State 1111 2 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M Marie J. Bennett 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICIMICS REGIONAL MEDICAL SALISBAI YENIN SULA Cente Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours 225-76-7874 **Director** 1 M 2 X F 04|17|1951 Louisiana Usual Residence of Dece 10c. City, Town or Location 10a. State 10b. County with the Maryland Items 23a or 28a-f sho her must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 1032 East Main Street be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 7 is marked other the Hair Dresser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Julian Porter Pat Quirk t. Page 1 and 2 should be treent of Health and Men rtant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Travers companion 1032 E. Main St., Salisbury, Maryland 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1
Department of
Important: If i
any Injury or o ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 07 27 2012 |Salisbury, Maryland 21. Signature of Funeral Service Licensee Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ SEPTIC SHOCK CIRHOSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner patre Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying 3 Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to to resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? 3 Pregnant at time of death Month 5 Other (specify) cate has been signed by the case page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate Yes 2 No 1 Yes 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Aft
d in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical ritifyi g Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medic Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certiping Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hound to the second 29a. Certifier (Check only one the 29b. Signature and title of ge 29d. Date signed (Month, Day, Year) MD D71972 30. Name and address of perwho completed cause of death (Item 23a) (Type, Print) 1006 CATTON St. SAMGER SHAIK - ABOUL 31. Date filed (Month, Day, Year) State 30 Registrar

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	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin E4 hours after death.  To the thereal Director After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buris	Medical	(Check 2 Medical Exami	ician: To the best of m ner: On the basis of exa e Practitioner: To the b	mination and/or investi	gation, in my opinic	on, death occurred	at the time, date a	nd place, and due	to the cause	e(s) and manner stated.			
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				- MD		DO	09086		July !	7.20	12			
			30. Name and address of person who c	ompleted cause of dea	th (Item 23a) (Type, Pi	int)		ا ماده	1 140	~ · · ·	-1			
	Stat		CHINTU STARM 31. Date filed (Month, Day, Year)	32. Register's	Signature 4	spri Cei	ا سياس	NEXTRIA	1113	7117	+			
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Gwendolyn D. Brown 12-05857 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 2012 2589 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 5, 2012 1357 hrs Medical Examiner Gwendo 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 1 1 2 X F 52 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Lyes 2 No 28a-f show death with the Maryland Director 10e. Street and Number 10a, Citizen of What Country? 209 13905 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-11. Marital Status 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 1 No Yes Specify: Black 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: 3 Widowed 2 Pages I and 2 should be filed within 72 hours a nent of Health and Mental Hygiene. art: If item 27 is marked other than "natura or other traumatic event, the Medical Exami 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Private Housekeener 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Jenkins Be Brown t and Number or Rural Route Number, City or Town, State, Zip Code) 19a. I mant's Name/Relationship (Type, Print ) 196 Mailing Addr 13908 Silver Cast Street eon Bown brothe 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 iverdale Park Donation 5 Other Specify 22. Name and Address of Facility Honges Signature of Funeral Service Licepsee FH Road JD 20741 Part I. Enter the disease, or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and failure. List only one cause on each line. /Medical a Complications of Chronic Narcotic Abuse Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and AMENDED #6, per fh, g930 8-14-12 sm 23a, 27, per me, g930 8-16-12 sm Physician/Medical e attending physician for use as the burial -X UNPENDED The law requires that the death certificate be Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown gΓ Unknown the signed by 1 be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Physiciao: Division of Vital Be Other<sub>4</sub> Hospital: 1 🗸 Inpatient 2 Nursing Home 5 Residence 6 Other: ER/Outpatient 3 D0A this 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending Certification: 1 X Natural Yes 2 No 5 Pending within 24 hours after death.

To the Funeral Director: 2 Investigation Accident 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be Suicide (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi O.C.M.E. August 6, 2012 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) AUG 1 4 2012 32. Registrar's Signature Registrar

	7	Plea	ase Type or Pri	nt in l	Black Ir	ndelible	e Ink	k. Ensure A	All Copie:	s Are Le	gible.			
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Funeral Director		5. Social Security Number 219-14-2028	6. Sex 1 M 2 X F 8		ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birl May 12	th y, Year , 1924	9. Birthr Coun Mai	place (State or Foreign try) cyland		
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/sicial s certi directo	To Be	examiner? 1  Yes 2  6	Hospital:	ent 2 🗆	ER/Outpatien	t 3 🗆 DO	Other	r: 4 Nursing H	ome 5 🗆 Resid	dence 6□0	ther (Specify			
nding Physician: 1 th. : After this certifics : funeral director, p		27. Manner of Death  1 Natural 5 □ Pendir	28a. Date of inju	ry	28b. Time of injury		c. Injury work?	at	28d. Describe h					
Attending death.	Certificate:	2 Accident Investig 3 Suicide 6 Could	gation not be	In. At he		M	1 🗆 Y	Yes 2 No	0001		D	D 1 M 1		
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the b.	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of e	xamination	and/or invest	igation, in m	y opinior	n, death occurred a	t the time, date a	nd place, and	due to the cau	ise(s) and manner stated.		
To the within 2 To the comple	ž	only one) 3 ☐ Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	best of my	knowledge, d			time, date and place number		e cause(s) and 29d. Date sigr				
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6 km		30 Name and address of person of	who completed cause of d	eath (Item		rint) 5 %	44	Ency:	Arec	BLKT	DX 1	nDalezi		
Stat	е	31. Date filed (Month, Pay, Year)	32. Registr	s Sign	/	/ 0		//			[ /	1/2/12/		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY 24. WILLIAM BODRICK 2012  $\mathbf{P}^{\mathsf{M}}$ 5:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's 8106 Elora Lane Brandywine Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 **F** Months Days Hours 84 1 294 9 27 **Director** 248-40-6045 SC Usual Residence of Decedent 28a-f show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Brandywine Prince George' MD Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20613 8106 Elora Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? ģ 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates**KOREAN** 1 ☐ Yes 2 ☐XNo Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed if Health and Mental H item 27 is marked ot ည Hallie Dash Robert Bodrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8106 Elora Lane Brandywine, MD 20613 19a. Informant's Name/Relationship (Type, Print) Mark Bodrick/ son Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, MD 8/3/2012 MD Veterans Cem. 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington RD Waldorf, MD 20601 sambelli ( lonce 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death COMPLICATIONS OF ALZHEIMER'S DEMENTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical use as yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No ō Month Day Year ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ **ESSENTIAL HYPERTENSION** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕇 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 24a. Was an autopsy performed? Yes 2 N death? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 2**X** No ൧ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural 5 Pending work 1 Yes 2 🗌 No neral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Box 68760

P.0.

Records,

of Vital

Division

State

31. Date filed (Month, Day, Year) 32. Registrar

KAREN ANN BLACKSTONE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifi

M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 egistrar's Signature

29c. License number

MD#33255

29d. Date signed (Month. Dav. Year)

JULY 26, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 07730/2012 Ethel Best 8:50a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Manor Care Dulaney Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 214-40-1586 1472277923 1 □ M 2 🕇 F 88 **Director** NC Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits MD Baltimore Towson XYes 2 No ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 West Road 21204 USA death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Domestic House Keeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Coley Bessie Lee Sampson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alex Adams/son 305 S. Baker St. Eureka, NC 27830 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State old Mill Cemetery 8/4/2012 1 Burial 2 Cremation 3 Removal from State Goldsboro, NC 4 Donation 5 Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licer 2294 Old Washington RD Waldorf, omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Montas **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) Examin physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 **X**No Other: 1 🗌 Yes မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work' within 24 hours after death.

To the Funeral Director: Af 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of D-12849

Registrar
DHMH 17 Rev 06-2011

7600

OSLER Dr. TOWSON MD 21204

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 07/97/2012 Year Susie Mae Curtis 5:00 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03/28/1923 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 213-38-1050 89 Director 1 □ M 2 F Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Clinton 1 X Yes 2 □ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9211 Stuart Lane 20735 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 14 Bace - American Indian or Black White etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify:Black 3 Nidowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Private Be Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Thompson Essie Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Robinson/dtr. 905 Kennebec St. Oxon Hill, MD 20745 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cem. 8/6/2012 Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service License Melly 2294 Old Washington RD Waldorf, 23a. Part 1. Enter the !-- ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 1 Yes 2 L g Unknown the a Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 2 🗌 No 1 Tes Yes 2 No Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ဂ္ 1 🗌 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Medical Certificate: 28a. Date of injury 28c. Injury at 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 (Month, Day, Year) 1—Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Side n45365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 livingston ad 1 10/ ft waskington MO 2078& Sidanous MD

DHMH 17 Rev 06-2011

Registrar

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12-05607 Walter Edward 0	Cecil			e or Print i								gible		10 000	) }-(		
		l- For State Registrar		,		Certificat				,,		eg. No.	20	12 258	)		
Physiciadical Exami	ın/	1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day Year July 27, 2012										3. Time of Death 1459 hrs					
		4a. Facility Name (if not institution, give street and number)       4b. City, Town, or Location of Death       4c. Coun         Memorial Hospital at Easton       Easton       Talbot									County of De	eath					
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/										Birthplace (State or						
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15-0036 filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or items 23a or 28s-f show t, the Medical Examiner must be notified at once.	<u>E</u>	11. Marital Status			cedent Ever		spanic Origin?					nerican Indian, 8lack,	_				
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	-	4 Donation 5 21. Signature of Funer	Other Speral Service L	icensee			22 Namo	and Addres	e of Eacility						_		
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		30. Name and address Pamela E. So	•				900 W	Baltimo	re Street, E	Baltimo	re, MD 2	1223					
	ate	31. Date filed (Month,			egistrar's Sig		and I								_		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day E1wood S. Cuffey 12:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Hospital Lanham Prince George's Funeral . Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Days Hours **Director** 579-40-9429 1 🖾 M 2 🗆 F 79 August 16,1932 Washington, DC 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 3a or 28a-f sh Prince George's Upper Marlboro Md 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20774 11104 Webbwood Ct. USA ral", or items? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 01 Black. White, etc. Completed by 1 Never Married 2 X Married X Yes and 2 should be filed within 72 hours after Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates. 1953 event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Postal Worker US Postal Service is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Men Important: If item 27 is marke any injury or other traumatic Sylvester Cuffey Josephine Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elnora E. Cuffey / Wife 11104 Webbwood Ct. Upper Marlboro, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place, 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 7/27/12 Brentwood, Md 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. 20722 Brentwood, Md 23a. Part 1. Enter the disea shock, or heart failure Immediate Cause (Final se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause and ach line. Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leauning to immediate cause. Enter Underlying Cause (Disease or injury Examine the attending physician and thed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? 1 Yes 2 No · Hospital or Attending Physician: ] 24 hours after death. · Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **N**o Other: 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of ce death (Item 23) (Type, Print) 20706

DHMH 17 Rev 06-2011

State Registrar Good Luck ROAD, LANHAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For _ State	State of M	1aryland /		irtment of l tificate of			lental Hy	_	2011	2 25898
			Registrar  1. Decedent's Name (First, Middle, La		2. Date of De	Reg. No. (	_ 0 1 1	3. Time of Death					
	Physicia			Francis		(	Coogan			Month July	Day 26	$2\overset{Year}{0}12$	4:00a <sup>M</sup>
	Medic Examin		4a. Facility Name (if not institution, giv			ì	4b. City, Town, o	or Location	n of Death	oury		unty of Death	
	<b>E</b> XCIIIII		Spring House of	Westwood			Bethese	la			Мо	ntgome	ery
Т	Funeral		,	Sex 7. A	ge (In yrs. last bi		If Under 1 Year Months Days	If Unde	er 24 Hrs. Min.	8. Date of Bir		9. Birt	hplace (State or Foreign
	Director		108-12-6425 Usual Residence of Decedent	<b>3</b> 2	91	Yrs.				097697	1920	N	ew York
	and show	ō	10a. State 10b. County		10c. City, Tov	wn or Loc	ation						10d. Inside City Limits
	Manyla 28a-f	10a. State   10b. County   10c. City, Town or Location   VA   Fairfax   Springfield   10f. Zip Code   10g. Citizen of											1 ☐ Yes 2 🛣 No
	a or 2	io le	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Co	untry?
	th with ns 23 must	ner	6603 Burlington				221.					ted St	
	r dear											Race - Amer Black, White	
036	s afte ral", c Exam	q pe	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1942 <b>-</b>	1	☐ Yes 2 🗵 No	Specif	fy:		Spe	ecify: Cau	ıcasian
2-0	hour "natu dical	plete	15. Decedent's (Specify only highest of	of Business I									
12	within 72 hours after death with the Maryland glene. gret than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.	Completed by	Elementary/Seconday (0-12)										
5	ed wit Hygie Ither	Be C	17. Father's Name (First, Middle, Last)	vernme name)	ent								
and	should be filed and Mental Hy r is marked oth raumatic event	2	Gerald Coogan					ı		t Whale		iarioj	
ary	nould ind Mi s mar umati		19a. Informant's Name/Relationship (	Type, Print)	19	9b. Mailin	g Address (Street					vn, State, Zip	Code)
Σ̈́	and 2 st Health a tem 27 is		Tim Coogan (son)		6	5603	Burling	ton P	lace,	Sprin	gfield	VA, 2	22152
ore	of He of He if item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	X Removal from Stat		of Dispos tery, crem	sition (Name of latory or other pla	ce)	D	ate	20c. Locat	ion - City or	Town, State
Ĕ	. Page tment o tant: If jury or		4 Donation 5 Other (Spec	ify)			emorial					ax, V	A
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer	M0095	56		Name and Addre Nirfax Me 102 Brade					22032	
Ė			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only						-				Approximate Interval Between
Immediate Cause (Final disease or condition a. Adult Failure to thrive											Onset and Death  1 Week		
	Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):							
		er	Sequentially list conditions,	b -	ners Dis				_				
	B _ B_	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	200 10 (0) 00	, a comocquemor	J 0.j.							
	execur in and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as	a consequence	e of):							
09	ate be executed ohysician and the burial transit	dical Examiner		d									
876	rtificar ing ph e as th		IF FEMALE:	00 15						· -			
Box 687	eath certifical attending ph	Physician/Me	23b. Was decedent pregnant in the past 12 months?		e of pregnancy 2  Fetal dea at time of death		Ectopic pregnan Other (specify)	су			23d	. Date of deli Month	very Day Year
ă.	ne dea / the a	nysic	1 U Yes 2 No 9 Unknown	g Unknown			Cirici (apociny) _						
P.O.	requires that the de been signed by the s should be detached	by Pl	Part II. Other significant conditions	contributing to death	but not resulting	g in the u	nderlying cause g	iven in Par	rt I.	23e. Did t	obacco use o	contribute to	the cause of death?
ds,	quires an sign	edk								1 🗆	Yes 2 🗆 N	No 3□Pr	obably 4 🔀 Unknown
Sor	law rec has bee	Completed								24a. Was auto	osv	prior to c	opsy findings available completion of cause of
Bě	The la	Con								perfo	ormed? 2 X No	death?	2 🗆 No
tal	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				lace of De	eath (Check	only one)	-		
Ž	Physical chiral	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ inpa 28a. Date of in	tient 2 ER/0	Outpatien . Time of	t 3 DOA 28c. Inju	4 <b>K</b>   1		ne 5 Resi			fy)
0 0	nding ith. : After e fune	30   27. Manner of Death   28a. Date of injury   28b. Time of   28c. Injury at   28d. Describe how injury occurred   28d. Describe how i											
Division of Vital Records,	Atter	rtifi	28a. Date of injury    1 \bigsim Natural   5 \bigsim Pending   28a. Date of injury   28b. Time of injury   28b. Time of injury   28c. Injury at work?   1 \bigsim Yes   2 \bigsim No.   No									ımber or Rur	al Route Number,
<u>&gt;</u>	tal or irs afte al Dir led in			building, e	ic. (Specify)					City or lov	vn, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transf	Medical	(Check 2 Medical Exar		examination and	or invest	igation, in my opin	ion, death	occurred at	the time, date a	and place, and	d due to the c	ause(s) and manner stated.
	othe vithin to the comple	Σ	only one) 3 ☐ Certifying Nu 29b. Signature and title of certifier	rse Practioner: To th	e best of my kno	wledge, d	eath occurred at the			e, and due to th		gned (Month	
	12+1		> Muchael	Mad	4		MD1590	01				26, 20	
			30. Name and address of person whe	completed cause of	death (Item 23a)	) (Type, P	rint)						
_			Dr. Michael Grad					, Was	hingt	on DC			
	Sta Registra		31. Date filed (Month, Day, Year)  JUL 3 0 20	37. Regist	rar's Signature	par	Kar						
	ricgisti	21	JUL 0 0 20	- La	- 1-	1.81							

700:0400

DOD: 7-26-2012

WILLIAM F. COOGAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012  $\mathbf{J}\mathbf{U}\mathbf{L}^{\mathtt{Month}}\mathbf{Y}$ 27, 12:35P M BAREFOOT DYER SUE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK HOSPITAL FREDERICK FREDERICK MEMORIAL If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. 577-48-9300 Director 1 □ M 2 🕱 F 74 1, 1937 Washington D.C. Usual Residence of Decedent show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🛣 No Frederick Monrovia Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 21770 United States 3802 Chaucer Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Secretary nt of Health and Mental Hygie t: If item 27 is marked other or other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Garrett Ralph Barefoot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olin L. Dyer / Husband 3802 Chaucer Court, Monrovia, Maryland 21770 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Department o Important: If any injury or once, Stauffer Crematory Inc.7/29/2012 Frederick, Maryland. 5 Other (Specify) 4 Donation uneral Service License used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause or Onset and Death Immediate Cause (Final Physician/ Ulmonavy disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Il any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, bage 2 should be determined. that initiated events Due to (or as a consequence of) resulting in death) Last Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ည 2 No 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 8c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5  $\square$  Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year 7-27-2017 MD D60417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ら Johnson Dr 65 c Thamas

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Frederica

			For State	i ica		of Marylar	nd / Depa	artment o	f Health	and Me	•	giene	nie.	25000
			Registrar  1. Decedent's Name (F	First Middle	l ast)		Cer	tificate o	Deam		2. Date of De	Reg. No.	116	29900
	Physicia		·	nat, widdie,	,	_					Month	Day	Year	3. Time of Death
2	Medic		Edward  4a. Facility Name (if no	t institution	Leroy		stin	4b. City, Town		a of Dogsh	July_		012	02:10.AM
	Examin	er	3. 4 /	1		17	11		/	n or Death	1	4c. County	of Death	
			Marylan, 5. Social Security Num	ther le	eneral Sex	7. Age (In yrs.	fell	ISQ/+	ar If Unde	er 24 Hrs.	8. Date of Birt	la la	C District	(Ot-t
-	Funeral Director		214-36-39		1 X M 2 D F	73	Yrs.	Months Day			(Month, Da	y, Year)	Counti	ace (State or Foreign
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	and shov	5	10a. State	0b. County		10c. Ci	ty, Town or Lo	cation					10	d. Inside City Limits
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	ems r mu	اجّا	11. Marital Status	St. St.	12. Was Dece	edent Ever in U.	S. 13. V	Vas Decedent of Yes, specify Co		rigin? (Speci	fy Yes or No-		- America	n Indian
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33%	's aff rral", Exa	pa	3 Widowed 4		I If Yes. Giv	<sup>/e</sup> at <b>₫</b> \$961 <b>−</b> 1	963	Yes 2 📑	No Specify	fy:		Specify:	Wh	ite
€ Dw/a, 215-0036	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by		15. Decedent	s Education		16a. Deced	lent's Usual Occ	cupation			16b. Kind of Bu	siness Ind	ustry
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X a	ild be fill Mental narked o	잍	Frank	Dusti	n				U	nk.				
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S.	1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If health and Mental Hygiene. It marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Patricia	Dusti	n (Wife)		410	l 31st.	Stree	t Mt.	Ranie	er, MD 20	0712	
ore.	of He		20a. Method of Dispos		Domayal fram	20b. f		sition (Name of natory or other p	olace)	Da	te	20c. Location -	City or Tov	vn, State
ンムムらせいん Baltimore, Maryland	permit. Page 1 and 2. Department of Heath Important: If item 27 any injury or other tr once.		1 Burial 2 A Donation 5	Other (Sp	ecify)	Md		. Cemete		8/3/2	2012	Chelte	enham	, MD
a <del>t</del>	rmit.	1	21. Signature of uner	al Service Lic	ensee /	1	22	. Name and Add	dress of Facil	ility Ren	ndon/Ha	ale Fune:	ral H	ome .
	90 = F 9		Ille	nous	19900	ues	<u> </u>	013 Anr	napoli	s Rd.	Lanhan	n, MD 20	706	1
			23a, Part 1. Enter the shock, or heart fa	disease, or c	omplications that	caused the deat	h. Do not ente	er the mode of d	lying, such as	s cardiac or r	respiratory arr	rest,		Approximate
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×	th ce trend or use	ian/	23b. Was decedent pre in the past 12 mo		1 Live	tcome of pregna Birth 2  Feta	al death 3						e of deliver	*
B -	the a	Physician/Med	1 Yes 2 1 N	Vo	4 ☐ Preg 9 ☐ Unkr	nant at time of a	death 5∟	Other (specify)				Mor	illi l	Day Year
P.O.	at the	F.	Part II. Other significa	ant condition	s contributing to d	leath but not res	ulting in the u	nderlying cause	given in Par	† I.	23e Did to	bacco use contri	bute to the	cause of death?
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<b>&amp;</b> §	cate										1 Yes		eath?	₽ ID No
घ	clan	m	25. Was case referred examiner?		Hospital:	LANS / W		1.		eath (Check o	nly one)			
<u> </u>	hysi this c	은	1 Tyes 2 12 N	Vo	1 🗹	Inpatient 2		t 3 🗆 DOA		Nursing Home	e 5 🗆 Resid	lence 6 🗌 Othe	r (Specify)	
Division of Vital Records,	Ing F	Certificate:		5 Pending		ot injury th, Day, Year)	28b. Time of injury	28c. in	ork?		d. Describe h	ow injury occurre	d	
ioi	death death tor: / the i	Eji	2 Accident 3 Suicide	Investiga 6	t bo	-61-1 - 811			Yes 2					
i Nis	or A after Direc in by	Se	4 Homicide	determin	ed 286. Place buildi	of Injury - At hong, etc. (Specify	me, rarm, stre	et, factory, offic	e	28	If. Location (S City or Tow	Street and Number n, State)	r or Rural F	Route Number,
	purs sours seral l		29a. Certifier 1	Cortificing D	hysician: To the b	est of my know	ladge death s	sourced at the ti	mo data and	d place and d	due to the ear	up a(a) = = = = = = =		
3	24 h	Medical	(Check 2 ∟	J Medical Exa	miner: On the bas lurse Practioner:	sis of examination	า and/or invest	igation, in my op	inion, death o	occurred at th	e time, date a	nd place, and due	to the caus	e(s) and manner stated.
4	To the hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the		only one) 3 L 29b, Signature and time		/	o the pest of m	y kilowiedge, c		nse number			e cause(s) and mar 29d. Date signed		<del></del>
	->-0		1 Mar	. 16	Muny	7			730			7.37	_	_
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	Stat	е	31. Date filed (Month, L	Day, Xear	00 / 37 R	egistrar's Signa	ture	716114	TOIN	/ 66	1007	1100		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7/25 2012 a Physician/ 2:59a Clarence Orlando Davis, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince Georges If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 578-80-6308 56 Director 1 X M 2 🗆 F 1/29/1956 Washington DC 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Upper Marlboro MD Prince Georges 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code P 10g. Citizen of What Country? 3710 Halloway North items 23a Funeral 20772 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 XMarried 1 Yes Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Special Police Officer Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Orlando Davis, Sr. Shirley Easton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tawanda Davis - wife 3710 Halloway N Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, injury ( 8/1/12 Chesapeake Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility W.H. Bacon Funeral Home 3447 14th St., NW Washington, DC 20010 21. Signature of Funeral Service Licensee any Wanda CC0361 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Connestive Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner anema Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner anemia Cause (Disease or injury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Dav Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ renat To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 H Vpertension performed 2 🗌 No Yes 2 No 1 Yes 25. Was cas referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Watural 5 Pending injury within 24 hours after death.

To the Funeral Director: A 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie July 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year,

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Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:10 WILLIAM DERRICKSON H. Medical 2013 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner DMI CO 8. Date of Birth **Funeral** Sex 1 X M 2 □ F 9. Birthplace (State or Foreign Months MAR. 6, 1928 DELAWARE Director 84 221-18-0087 Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director SEAFORD DELAWARE SUSSEX 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 900 WEST LOCUST STREET 19973 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRODUCTION PLANNER MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HANDY DERRICKSON ETHELYN HUDSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA H. DERRICKSON/WIFE 900 WEST LOCUST ST., SEAFORD, DE 19973 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GEORGES CEMETERY 7/30/12 CLARKSVILLE, DELAWARE f Fineral Service Licenses 21. Signatur 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ D10014 disease or condition Medical resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed No Jas 2 340 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes HOSPI GE မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence State (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending thin 24 hours after death.

the Funeral Director: A mpleted filled in by the fu М 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2.
To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature TO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAR 1500

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #26, PER MD G930 8/30/12 TRT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Duncan Physician/ Month August Eleanor Zo12 17:054 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10375 Boca Raton Drive Ellicott City Howard 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Min. Director 579-22-6336 1 □ M 2 🗓 F December 1925 86 Washington.D.C 10b. County with the Maryland in than "instural", or Items 23a or 28a-f sho the Medical Examirer must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Forest Avenue 20850 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ş 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced Completed Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) t. Page 1 and 2 should be filed with thrent of Health and Mental Hygler trant: If Item 27 is marked other 1 jury or other traumatic event, ID Clerk County Court 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph R. Hughes Margaret B. Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103/5 Boca Raton Drive Ellicott City, Maryland 21042 Bernadette Zabel/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If Ite any Injury or ot once. Date 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) August 10, 2012 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery Rockville, Maryland 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 M00335 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death END-Stage Pnysician/ Cardiomyopathy disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): death certificate ba executed To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlai-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 morffhs?
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home (Daughter's) RESIDENCE 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar DHMH 17 Rev 06-2011

State

Smith AV

DOUS 7465

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5

back

Baltimore MO

29d. Date signed (Month. Day, Year)

816/12

21209

ns Rajapathe MD

NS Kajupakse MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Chat	epartment of Health and	Mental Hygie	ne 2010 acol								
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg									
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an the land	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	AUGUST	4c. County of Death								
-	<i>J</i>		12452 Ashton Road	Clear Spring		Washington								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd			Birthplace (State or Foreign								
	Director		218-38-0834 1 M 2 □ F 68 Yrs	S. Wolldis Days Hours Will	n. (Month, Day, Ye 06/18/194									
	ind show	5	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town o	Location	100/10/1/	10d. Inside City Limits								
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	death item		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,								
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yla	should be fil h and Mental 7 is marked ( raumatic ev	70	George William Davis	Alice	e M. Bray									
Baltimore, Maryland 21215-0036	ge 1 and 2 should bo it of Health and Mer I <b>If item 27 is mark</b> o or other traumatic			ailing Address (Street and Number or F										
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nor	permit. Page 1 Department of 1 Important: If it any injury or o		1 X Burial 2 Cremation 3 Removal from State cemetery, of	rematory or other place)		c. Location - City or Town, State								
ij	permit. Pag Departmen Important: any injury once.		21. Salatur of Funeral Service Dengard		0//2012 War 141 WEst Ma	fordsburg, PA								
ñ	Dep Imp		1 1 1	Grove Funeral Home										
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	Medical Examiner		resulting in death)  a. Due to (or as consequence of):	iong weins,	ne	9 years								
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09	death certificate be executed re attending physician and ed for use as the burial-transit	dical												
376	ficate g phy as the	Medi	- U											
ő	eath certifica attending pl	an/	IF FEMALE:   23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1	B   Ectopic pregnancy		23d. Date of delivery								
Box 687	he death / the att .ched fo	Physician/Me		5 Other (specify)		Month Day Year								
P.O.	at the d by t letach		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I	00 - Diddel									
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Records,	sician: The law significate has k lirector, page 2 s	Completed			autopsy performed	prior to completion of cause of								
<u>~</u>	an: Th tificat tor, pa	Be C	25. Was case referred to medical	26. Place of Death (Che	1 Yes 2	1 Yes 2 No								
<u> </u>	nysicii lis cer direc	일	examiner? 1  Yes 2 No  Hospital: 1  Inpatient 2 ER/Outpa	Other:	Home 5 Residence	6 ☐ Other (Specify)								
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o	tendi death. tor: A the fi	<u>i</u> į	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No										
Division of Vital	or Al after ( Direc	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)								
		edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	h occurred at the time, date and place	and due to the cause/s	s) and manner as stated								
	n 24 h	Med	(Check 2 Medical Examiner: On the basis of examination and/or invonly one) 3 Certifying Nurse Practitioner: To the best of my knowled	estigation, in my opinion, death occurred	l at the time, date and pla	ace, and due to the cause(s) and manner stated.								
	Vithi Cong		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)								
	6 11		Michael Mulound M.	0 41667	)	8.4.12								
	25		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	1 Come	w baserohen MO.								
	State	2	Michael McComack  31. Date filed (Month, Day, Year)  AUG 1 4 2012  AUG 2. Registrar's Signature  Aug 2. Aug 2. Registrar's Signature	illo medica	1 com	MascroNum MO.								
	Registra	_	AUG 1 4 2012 June 2. Ja	Med										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0510PM Willie Hastings Elliott 07 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Center NICOMICO TENINSULA REGIONAL 5/4/564164 7. Age (In yrs. last birthday) 5. Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) Director 1 M 2 XF Usual Residence of Decedent 95 09/14/1915 Virginia בי וא ווזמרהפט other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Extininer must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director VA New Church Accomack 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7256 Fleming Road 23415 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: and Mental Hygiene. Is marked other than "natural", 3 X Widowed 4 ☐ Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Health Care of Health and Mental Hygi of Health and Mental Hygi fitem 27 Is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Hastings Bessie Justice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Elliott/ Son 35028 Sign Post Rd., New Church, VA, 23415 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wattsville Cem, 07/28/12 Wattsville, VA 22. Name and Address of Facility Holloway Funeral Home, P.A. 21. Signature of Fundal Service Licensee Vine Street, Pocomoke City, MD 21851 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) signed by the at Id be detached fo 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been sig 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Hospital or Attending Physician: the 124 hours ther death.
 Funeral Director: After this certificate I stelly filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No Natural 5 Pending 2 Accident Investigation 6 Could not be 3 
Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature 29d. Date signed (Month, Day, Year) H005609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120 SALLY 2 3 100 31. Date filed (Month JUL 3 egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2012  $\mathbf{A}^{\mathsf{M}}$ KARL FREDRIC EGER JULY 30 8:17 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE CENTER If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth Funeral (Month, Day, Year) Months Days Hours Min. Country) 034-07-3193 Director 1 😿 M 2 🗆 F 96 MASSACHUSETTS Yrs JAN.22,1916 Usual Residence of Decedent of Merial Hygiene. marked other than "natural", or Items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Page 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Heath and Mental Hyglene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho Director 1 🗆 Yes 2 🗶 No TOWSON BALTIMORE MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21204 1055 W. JOPPA ROAD, APT. 630 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) WESTINGHOUSE ELECTRIC ENGINEER 12 other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LUCY AVERY CHARLES EGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1055 W. JOPPA RD., APT. 630, TOWSON, MD 21204 FRANCES EGER/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite eny Injury or ot once. AUG. 1, 2012 CHURCH, HILL CEMETERY CHURCH HILL, MD 21, Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, LIBERTY ST., CENTREVILLE, MD 21617 408 S. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final +nysician/ resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). ettending physicien end for use as the burlal-transit Hospital or Attending Physiclen: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the e 9 Unknown After this certificate has been signed by inneral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed. 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 40501 CR 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nly one)

State Registrar 31. Date filed (Mor

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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44105, Balthouse, MO 21204.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 259 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 2012 26<sup>bay</sup> AM 5:45 Gladys Bowen Faulkner Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline Denton Envoy of Denton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours. Min Country) Maryland 11/3/1916 95 Director 220-01-9965 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. and: If item 275 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 No Denton Maryland Caroline 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21629 USA 611 Market Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceus. Armed Forces? <sup>4</sup> ☐ Yes 2 ☐ No 14 Bace - American Indian 11. Marital Status Black. White, etc. 1 XNever Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Private Business H.S. Grad. Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Nora Grace Tingle John Wesley Faulkner, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sudlersville, Maryland 21668 Department of Health Important: If item 27 any injury or other to once. 516 Cemetery Road <u>Bettv E. Faulkner/Sister-in-law</u> 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place, 1 🎇 Burial 2 □ Cremation 3 □ Removal from State Sudlersville Cemetery 7/30/2012 Sudlersville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lic as e Moore Funeral Home, P.A. Karloset nook Denton, Maryland 21629 12 South 2nd Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician acute myelogenous disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has be irector, page 2 s autopsy performed death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) director, Be examiner? 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at work? 1 \square Yes 2 \square No 28d. Describe how injury occurred 1 Natural injury 5 Pending 24 hours after death.

e Funeral Director: A pleted filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar

(Check

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

within 2 To the F

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3683

Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

200233222

Chaptank Rd Preston MD

29d. Date signed (Month, Day, Year)

Doia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Physician/ Ione Day 27 Freeman 3:55 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3114 Gracefield Road, WC 402 Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 215-44-8375 1 □ M 2 🐴 F Yrs 101 Sept. 3, 1910 Missouri should be filed within 72 hours and and Mental Hygiene.
7 is marked other then "natural", or items 23a or 28e-f show arrestic event, the Medical Example at most be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 🔀 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3114 Gracefield Road, WC 402 20904 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Commodity Specialist Federal Government traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Gilbert Stuckey Buena Vista Hahn permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is marku any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl L. Freeman/Son 1031 Parker's Fort, Greensboro, GA 30642 Baltimore, July 27, 2012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropoli<u>tan Crematory</u> Alexandria, VA 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver 21. Signature of Funeral Service Licenses Home Inc. comes MD 20901 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intracerebral Hemorrhage, non-traumatic disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funerel Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the bu attending physician and for use as the bulial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month 1 ☐ Yes 2 to 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Hypertension 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2x No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🔀 Residence 6 🗌 Other (Specify) 1 ☐ Yes 2 🗓 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours To the Funerel I Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OT/27 D12121 person who completed cause of death (Item 23a) (Type, Print) 3929 Ferrara Drive, Silver Spring, MD 20906 George F. Sengstack, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra/AMEND#23boer/MD,7/30/12,BMV,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\mathbf{J}_{\mathbf{u}}^{\mathrm{Month}}$ <sup>Day</sup>012 24, 6:02 Рм Morris Farbman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Leisure World 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Davs Hours New York Director 087-03-6105 101 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 15101 Interlachen Drive #910 20906 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give res, Give Year or Dates. 1942–1946 Specify: Caucasian 3 X Widowed 4 □ Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) New York City College (1-4 or 5+) -2-Elementary/Seconday (0-12) Accountant Housing Authority Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jacob Farbman Celia Epstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven B. Farbman - Son 5417 23rd Street North Arlington, VA 22205 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 29, 2012 Pinelawn, New York Beth Moses Cemetery Jefferson Funeral Chapel 21. Signature of Funeral Service Lice 22. Name and Address of Facility Haran mo1530 5755 Castlewellan Drive Alexandria, VA22315 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Snset and Death Physician pertensive disease or condition resulting in death) Medical Due o (or as a consequence of) Examiner Congestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial traesi signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascula Accider 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 124 hours after death. • Funeral Director: After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: မ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2

To the 8 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar/MFND#23bperMD, 8/6/12; BWW, McCo Certificate of Death cedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ JITA Ves 458aM 2012 07 Medical 4c. County of Death
Prince George e street and number **Examiner** 4b. City, Town, or Location of Death aps If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or I **Funeral** Days Hours May 28, 1942 **Director** 2 🗀 or 28a-f show City, Town or Location death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** Rainier 1 🗌 Yes 2 No Maryland 10f. Zip Code Street and Number 2071 or items 23a united 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever Armed Forces? 1 Yes 2 No 11. Marital Status 12. 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or any injury or other traumatic auxon. þ 1 Never Married 2 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working hife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) inte Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, ျ ira ves 19a. Informant's Name/Relationship (Type, Print) W: C 19b. Mailing Address (Street and Number or Javes 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Deremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) ero; (00 2001) Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months Month Day Year Pregnant at time of death Yes -1 ☐ Yes — 23 9 ☐ Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 1110 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? has within 24 hours after death.

To the Funeral Director; After this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practitioner: To the Sect of my knowledge 29b. Signature ar itle of certifie 29c. License number 29d. Date signed (Month, Day, Year) D63688 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Drive, Cheverly Maryland 20785 aivis 3001 Date filed (Month, Day, Year, Registrar's Signat State 30 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Genrales 1:40 P M 1 a mes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3049 Aberdeen Road Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Days (Month, Day, Year) 188-20-7553 87 **Director** 1XXM 2 | F Yrs May 13, 1925 Pennsylvania r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3049 Aberdeen Road Funeral 21403 U.S.A. death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

NO 2 No Black, White, etc. \$ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1943–46 1 ☐ Yes 2 No Specify. White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Associate Professor U.S. Naval Academy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles M. Gehrdes Marquerite Lego 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delora Gehrdes/wife 3049 Aberdeen Road Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State permit. Page Department of Important: If MD Veterans Cemetery : 8/7/2012 4 ☐ Donation 5 ☐ Other (Specify) any injury Crownsville, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signatur Funeral Service License odd 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pulmonary Immediate Cause (Final Obstructive Physician/ disease or condition resulting in death) Vears Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Month Day Pregnant at time of death ed by the a detached f 1 Yes 2 9 Unknown 9 Unknown s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ nath 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an mell After this certificate has funeral director, page 2 performed<sup>a</sup> 2 🗆 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ္ခ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: Aft
empletely filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation М 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the L within 2. To the F only one 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #201 2103 Bravertin Killian Stephen 31. Date filed (Month, Day, Year) 32. Re State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 8:38 a M 2012 July Giragossian Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** (Month, Day, Year) Months Hours 121-32-8684 **Director** 1 M 2 X F 68 Yrs Oct. 1, 1943 Greece Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County at the Maryland Director notified 1 Yes 2 X No Silver Spring MD Montgomery 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number ò ral", or items 23a o Examiner must be Completed by Funeral Page 1 and 2 should be filed within 72 hours after death with in ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a 20910 USA 8505 Springvale Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Jr than "he. "he Medical F 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) Classical Pianist Music Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Rose Arsenian Richard Giragossian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3179 18th Street, NW, Washington, DC 20010 Department of Health a Important: If item 27 is any injury or other trainonce. Diana Hellinger/Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition  $Ju1_{\mathbf{v}}^{Date}$  28 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place)
Metropolitan Crematory Alexandria, VA 2012 4 Donation 5 Other (Specify) Francis Adjess Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Hemoptysis disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Recurrent Adenocarcinoma of Lung Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Day After this certificate has been signed by the atter funeral director, page 2 should be detached for in the past 12 months? Month Year Pregnant at time of death Other (specify) g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 🗷 No Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA မှ Certificate:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the control of the Funeral Director. Division of Vital Records, P.O. Box 68760 ours after death.

leral Director: Ai
filled in by the fu completely

7. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year) 286. Time of injury M	work? 1  Yes 2 No	28a. Describe now injury of	scurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, far building, etc. (Specify)	ctory, office	28f. Location (Street and N City or Town, State)	lumber or Rural Route Number,
Check 2 Medical Evaminer	an: To the best of my knowledge, death occurr : On the basis of examination and/or investigation Practitioner: To the best of my knowledge, death	<ol> <li>in my opinion, death occurred :</li> </ol>	at the time, date and place, an	nd due to the cause(s) and manner
9b. Signature and title of certifier	$\Lambda\Lambda$	29c. License number D73240		signed (Month, Day, Year) 26, 2012
O. Name and address of person who com Anisha Kumar, MD	pleted cause of death (Item 23a) (Type, Print) 1500 Forest Glen F	toad, Silver Sp	oring, MD 209	10

State Registrar

Medical

3 0 2012 31. Date filed (Month,

parled.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Physician/ DUN JOSEPH GUTTER 1750 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Medstar St. Mary's Hospital St. Mary's Leonardtown 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 136-32-0405 1 1 1 M 2 □ F Months Hours August 25.1940 New Jersey Director Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Loudoun VA Ashburn 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21684 Kings Crossing Terrace 20147 USA 12. Was Decedent Ever in U.S.
Armed Forces? 1967
1 2 Yes 2 No 1984 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1967 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) traumatic event, the Lieutenant Colonel USMC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alth and Mental H ပ Anna Barna Samuel Gutter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Virginia Gutter/Wife 21684 Kings Crossing Terrace Ashburn, VA 20147 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🛭 Burial 2 🗆 Cremation 3 🗀 Removal from State Arlington National Cemetery 9/5/12 Arlington, VA 22203 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility nary Murphy FH 4510 Wilson Blvd. Arl., VA 22203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ SEPTIC SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PERFORATEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): SMALL CELL LUNG STAGE TV Cause (Disease or linjury and-tran that initiated events resulting in death) Last physician the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Pregnant at time of death Month Day 9 Unknown Division of Vital Records, P.O. ð Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completed filled in by the funeral Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I Gertifying Nurse Practioner: To the best of my knowledge, but 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69683 07/29/2012 Kullin MD 69N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LVIZ ST. MARRY'S MALINI 32. Registrar's

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 201°2 Zula Viola Gallaher 0656 Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital E1kton Ceci1 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2 🕅 F March 3, Year 921 North Carolina Director 219-10-8424 91 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 287 Russell Road 21921 United States death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married \$ 1 ☐ Yes 2 🔀 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 🗌 Yes 2 💢 No Specify: "natural" 3 X Widowed 4 □ Divorced Completed White Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megines. Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Eastridge Mary Ann Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Caldwell/Son 8 Tally Ho Drive, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Cherry Hill Methodist Cemetery Methodist Cemetery August 14 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Cherry Hill, MD 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Endometria Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death g Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 28 completed filled in by the funeral director, page 28 autopsy perform death? 2 XNo 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 IX No 1X Inpatient 2 ER/Outpatient 3 DOA 욘 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1-X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062190 MD 6 12 KHANMD SHAHNAWAZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2533 AUGUSTINE HERMAN HWY SUITE A, CHESAPEAKECITY, MD 21915 31. Date filed (Month, Day, Year) AUG 1 4 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Robert. T. Hobbs July 04:48 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign (Month, Day, Year) Hours 75 **Director** 214-36-1604 1 🕱 M 2 □ F Feb. 13 1937 Maryland Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified Gaithersburg MD Montgomery 1 Tyes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20879 117 Watkins Mill Road, Apt. B United States death \ Was Deceus.
Armed Forces?
Vas 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 1 X Never Married 2 Married Black, White, etc. ō þ 1 Yes 2 If Yes, Give Year or Dates 21215-0036 Exami 1 Yes 2 No Specify. White "natural", Specify: Completed 3 Widowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Exterminator Pest Control is marked other taumatic event, the 0 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Fannie Mae Leizear 27 is marked or traumatic e William T. Hobbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11113 Crystal Falls Drive, Smithsburg, MD 21783 Andrew Snow/Executor permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Colesville Cemetery 07/31/12 Colesville, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Barber Funeral Home P.O. Box 5038, 20882 Laytonsville, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ar dia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Due to jor as a constiguiring of Exam Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): as the burialsigned by the attending physician dedetached for use as the hiring Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year 1 | Yes 2 L 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 8c. Injury at 1 Natural iniury 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hou

To the Funer

completely file 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive, Rockville **(**5 Sherrill MD 9901 Medical

Registrar
DHMH 17 Rev 06-2011

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Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Day 2012 Year 26, Dolores Marie 9:26A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9916 Golf Course Road #10 Ocean City Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year) Director 24 8611 1 □ M 2 💢 F 86 Yrs. Usual Residence of Deceden June 26,1926 Maryland ed other then "nature!", or items 23e or 28e-f show event, the Medical Examiner must be notified at i and 2 should be filed within 72 hours after death with the Maryland f Heaith and Mantal Hyglene. Item 27 is marked other then "naturel", or items 23e or 28e-f shov 10b. County 10c. City, Town or Location Director 1 Yes 2 No <u>Maryland Worcester</u> Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9916 Golf Course Rd. 21842 U.S.A 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 ☐ Never Married 2 🂢 Married 21215-0036 If Yes, Give 1 ☐ Yes XX No Specify 3 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Housewife</u> Homemaker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Albert E. Bender Emma Elizabeth Messenger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Vincent Heim 9916 Golf Course Rd.#10 Ocean City, MD injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 💭 Cremation 3 🗀 Removal from State First State Crem.: 7/30/12 4 Donation 5 Other (Specify) Millsboro, DE 21. Si vilu eny in 22. Name and Address of Facility 108 William St. The Burbage Funeral Home Berlin, Part 1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Onset and Death Priysician/ arkinson S disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner mentia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 4 Pregnant a Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No B B 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b, Sig 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) ann ach LL Dostan

Registrar

DHMH 17 Rev 06-2011

State

31. Oate filed (Month, Day, Year) 3 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Arnold Bobby Hooks Medical Facility Name (if not institution, give street and number Examiner 4c. County of Death 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Min. Hours Director 214-42-9910 Usual Residence of Dec 1 X M 2 - F 08|01|1938 Maryland or 28a-f shov 10a. State 10b. County 10c. City, Town or Location daath with the Maryland item 27 is marked other than "natural", or itams 23a or 28a f sho other traumatic avent, the Medical Exciptor must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Worcester Pocomoke City 10f. Zip Code 10g. Citizen of What Country? Funeral 21851 409 Linden Ave., Clarke Manor Apts. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Claude Hooks Goldie Reynolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Opal Izetta Christy|P.O.A. 911 Cedar St.,Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07 27 2012 Salisbury, Maryland Salisbury Crematory 21. Signature of Funeral Service Ligensee .22. Name and Address of Facility HOLLOWAY Funeral Home P.A Kell Vine St., Pocomoke City, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCIE hysician/ MALIG disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): 24 hours aftar daath. • Funeral Director: Aftar this certificata has baan signad by tha attanding physician and ataly filiad in by tha funaral diractor, paga 2 should ba datachad for usa as tha burlai-transit Hospital or Attanding Physician: The law raquires that the death cartificate be axacuted that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3/☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) CSA CR မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 27. Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 9 ☐ Natural 5 Pending 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical within 24 hou To the Funel complataly fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one å 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10005 8410 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) WAR 31. Date filed (Month, Day) 32 legistrar's Signati State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Pear Physician/ July 10:32 PM 27, Harriet Freda Husman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Worcester 1135 Ocean Parkway Unit 2B Ocean Pines If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Country) Director 342-16-9279 1 □ M 2 🔀 F 90 9-19-1921 IL Pege 1 and 2 should be filed within 72 hours efter death with the Msryland ment of Heelth and Mental Hyglene. ant: If Item 27 is merked other than "neture!", or Items 23e or 28e-f show ury or other traumetic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Ocean Pines MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 USA 1135 Ocean Parkway Unit 2B 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 🗆 Widowed 4 😡 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) University of Elementary/Secondary (0-12) College (1-4 or 5+) Maryland Secretary 8 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ambia Harold Pirtle Lydia Gault 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cambridge Place Ocean Pines, MD 21811 Fred Husman- Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State First State Crem. 7-30-12 Millsboro, DE 4 Donation 5 Other (Specify) 21. Signature of Fyneral 22. Name and Address of Facility Burbage Funeral Home William street Berlin, Part 1. Enter the disease, or complications shock, or heart failure. List only one cause ease, or complications that caused re. List only one cause on each line. sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter th Approximate Interval Between Onset and Death Immediate Cause (Final Bhysician/ evenu disease or condition resulting in death) Medical Due to (or as a consequence of) <sup>d</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury) Due to (or as a consequence of) within 24 hours efter deeth. To the Funerel Director: After this certificete has been signed by the ettending physicien end completely filled in by the funerel director, pege 2 should be deteched for use es the buriel-trensit Hospitel or Attending Physicien: The lew requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 9 Unknown Day 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Yes No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗆 No Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signa title of certifie 29d. Date signed (Month, Day, Year) 0-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 30 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Willie D. Hailstock Julv 2012 2210 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth Hours (Month, Day, Year) 238-60-9179 70 1 🛛 M 2 🗆 F 11/21/1941Winston Salem Usual Residence of Decedent 10c. City, Town or Location MD Baltimore Baltimore City 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 1901 West North Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Specify: BLACK 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Proprietor Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie D. Wright Jane Hailstock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JaJuan Hailstock/ Son 7915 Ashford BLVD. Laurel MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place. 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spe July/21/12 Riverdale Maryland Riverdale Pk Crem 21. Signature of Funer ervice Lio 22. Name and Address of Facility Tyrone J. Young Funeral Svc. 5635 Eads Street NE Washington DC 20019 23a, Part 1 Part 1. Epter the disease, or conshock, or heart failure. List only caused the dea o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death disease or condition resulting in death) ardiopulminary Arrest Due to (or as a consequence of) Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Bowel Obstruction that initiated events resulting in death) Last Due to (or as a consequence of):

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

Completed by

Be

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Examiner

**Funeral** 

**Director** 

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ms 23a or 28a-f s must be notified

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Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical I

item 2 other

Department of H Important: If ite any injury or oth

the Maryland

death with

permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036

> Exami burial-trar Be Completed by Physician/Medical Medical Certificate: To

the attending physician the doring the burial Hospital or Attending Physician: The law requires that the death certificate be to a flow after death.

Funeral Director: After this certificate has been signed by the attending physicis. completely filled in by the funeral director, page 2

Division of Vital Records, P.O. Box 68760

2JM

24 hours a

only one) 29b. Signature and title of cert

Sirak Lemma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500

Registrar's Sign

Forest

MD

To the within 2

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1  Live Birth 2 Fe 4  Pregnant at time of	tal death 3 🔲 Ectopi	c pregnancy (spec <i>ify)</i>		23d. Date of delivery Month Day	y Year						
Part II. Other significant conditions	contributing to death but not re	sulting in the underlyin	g cause given in Part I.		o use contribute to the ca							
				24a. Was an autopsy performed'	? death? _	etion of cause of						
25. Was case referred to medical examiner?		26. Place of Death (Check only one)										
1 Yes 2 X No	Hospital: 1 😾 Inpatient 2	BR/Outpatient 3	DOA Other: 4 Nursing I	Home 5 Residence	6 ☐ Other (Specify)							
27. Manner of Death  1      Natural 5 □ Pending 2 □ Accident □ Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred							
3 Suicide 6 Could not 4 Homicide determined	1 28e Place of Injury - At h		ory, office	28f. Location (Street : City or Town, Sta	and Number or Rural Rou ate)	ıte Number,						
(Check 2 Medical Exar	ysician: To the best of my knowniner: On the basis of examinations of examinations of the best of	on and/or investigation, i	in my opinion, death occurred	at the time, date and pla	ace, and due to the cause(s							

29c. License number

D65069

Glen Road Silver Spring MD. 20910

29d. Date signed (Month, Day, Year)

07/20/2012

DHMH 17 Rev 06-2011

State

Registrar

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Č	21213-0036	rs alter or rral", or it Examine	Completed by F	1 Never Marr	ried 2 Married 4 Divorced	Armed Forces?  1  Yes  If Yes, Give Year or Dates.	No		1 Yes				rican, etc.)		Black Specify:	k, White, et	ite	
r.	2-c	"natu	plet	(Spe	15. Decedent's ecify only highest of	Education grade completed)		(G	ecedent's Usi Rive kind of w	ork done a	luring mo:	st of workin	g	16b.	Kind of Bu	siness/Ind	ustry	
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20	and	be nied w ental Hygi ked othe ic event,	To Be	17. Father's Name (		)							(First, Middle,	, Maider	n Surname)	)		
	Maryland	alth and Math and Math and Math and Manager is manager in traumat	3	19a. Informant's Na	ame/Relationship	(Type, Prin <b>īHolst</b> e <del>ser</del> Spouse	ge	19b. M	Mailing Addres	ss (Street a	and Numb	oer or Rural ive M	Route Numbe	er, City o	or Town, St 1e,MD	ate, Zip Ce 2110	ode) 18	
Holst	baltimore,	permit. Fage 1 and 2 should be filed within 72 hours after death with the wayyand begind partners of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.				Removal from State	20b. I	Place of Dicemetery,	isposition (Na crematory or est Ce	ame of other plac meter	e) Y		ate /2012	l .	Location - napo1			
He	Balti	Departm Departm Importa any inju		21. Signatur			'		22. Name a	and Addres	ss of Facil	ity al Ho	me P.A	.85 .Gar	l Ann	apoli Is,M	5°21054	
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	P	h, sician/ Medical	0.70	Immediate Cause disease or condition resulting in death)	(Final on	a. Hype	DXIC	- 14	D) Ca	tory	1	all	ce				Onset and Death	
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	BOX 6	to the Prospiral of Authoring Priyacian: The law requires that the death Centificate by within 24 hours after death.  The Funeral Inector: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bit.	Physician/Medical	23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	Months?	23c. If yes, outcome 1  Live Birth 4  Pregnant 9  Unknown	2 Fet at time of	tal death	3 Ectopic 5 Other (s						23d. Date Mor	e of delive	ry Day Year	
(	S, F.C.	signed by		Part II. Other signi	figant conditions	contributing to death	but not re	sulting in t	the underlying	g cause giv	en in Par	t I.			use contri 2 🗌 No		e cause of death? ably 4 1 Unknown	1
	cord	has been le 2 shoul	Completed by										24a. Was	DSV	p	rior to con	sy findings available	_
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	Vita	ysician: The law is certificate has be director, page 2 s	To Be	examiner?	No	Hospital:	itient 2	BR/Outp	atient 3 🗆 I	Oth	or:		ne 5 $\square$ Resi	idence	6 🗆 Othe	r (Specify)		
	n of	tth. * After thise funeral		27. Manner of De t  1 Natural 2 Accident	th 5 Pending Investigat	28a. Date of in (Month, D	jury	28b. Tim inju	ne of	28c. Injury work	y at	2	8d. Describe					
	Division of Vital Records,	al or Atters after des I Director de in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of Ir	njury - At h etc. <i>(Specif</i>		, street, facto	ory, office		1	28f. Location ( City or To			r or Rural i	Route Number,	
		to the mospital or Attending Prily, within 24 hours after death.  To the Funeral Director, After this completely filled in by the funeral di	Medical	(Check 2	2 Medical Exa	hysician: To the best of miner: On the basis of urse Practitioner: To t	examination	on and/or ir	nvestigation, i	n my opinio	on, death	occurred at	the time, date	and plac	ce, and due	to the cau	se(s) and manner state	ed.
1		vithi To th		29b. Signature and	I title of ceptifier	UG M	(1)		29	9c. License	number 0 3	2740	1	29d. D	Date signed	(Month, D	2012	
		92		30. Name and addr	/ 2 -	o completed cause of MC	death (Iter	m 23a) (Typ	pe, Print)	itel	to	W (	alen "	BU	nic	1	10	
		Sta Registr		31. Date filed (Mon	th, Day, Year) JUL 31 2	2012 32. Pegist	trar's Signa	ature.	back	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kathy Heneghan Ellen Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death **Examiner** Medica 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 212-66-3577 Hours Director 1 □ M 2 🛚 F 59 1/28/1953 Washington, DC or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 X No Waldorf Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 2512 Ryce Drive 20601 USA Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 Yes : 1 Yes 2 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Security Specialist/Supervisor Dept. of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maxson Ε. McCarry Helen I. Sellner injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick J. Heneghan, Jr. / Son 103 Junction Court, La Plata, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 3 Cremation 3 Removal from State PIPPO New Life Cemetery 8/1/2012 La Plata, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Signature 6160 Oxon Hill Rd. Oxon Hill, MD 20745 Part . Enter the disease, or complicati shock, or heart failure. List only one comt caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 pronths?
1 Yes 2 No Day Pregnant at time of death Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Probably 4 Unknown 1 🗌 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 page 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 2 Accident Investigation within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Y (Item 23a) (Type, address of person istrar's Signature

Registrar

			Pleas	e Type or Pri					Mental Hy		_egible.	
			For State	State of M	aryland		tificate of		wentai ny		201	0 0=00
			Registrar  1. Decedent's Name (First, Middle, Lo	ast)	-	Cer	uncate or	Death	2. Date of De	Reg. No.	<del>4</del> U +	3. Time of Death
н	Physicia		Margaret Harri	son Houc	k				July 2	Day	Year 2012	3:50 P <sup>M</sup>
and the	Medic Examin		4a. Facility Name (if not institution, given				4b. City, Town, o	or Location of Dea			ounty of Death	1 3.30 1
			Holy Cross Hospi	tal				er Sprin			Montg	omery
	Funeral				je (In yrs. las	st birthday)	If Under 1 Year Months Days			th y, Year)	9. Birth Cour	place (State or Foreign itry)
	Director		Usual Residence of Decedent	1 □ M 2 🖾 F	77	Yrs.			Sept. 2	2, 19	34 NJ	
	and show	힏	10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
	Maryl 28a-f otifie	rec	MD P.G.			Co116	ege Park					1 ☐ Yes 2 ☐XNo
	72 hours after death with the Manyland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Funeral Director	10e. Street and Number				10f. Zip Code				en of What Coul	ntry?
	th wit	ner	9299 Rhode Isla		Evenie II C	140.11	2074				JSA	
<b>'</b> 0	or ite	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☒ Married</li></ul>	12. Was Decedent Armed Forces? 1 Yes 2	Ever in U.S.	.   13. V	Vas Decedent of F Yes, specify Cub	. Race - Americ Black, White,	etc.			
036	s afteral",	q pa	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	110	1	☐ Yes 2 🔀 No	Specify:		Sp	pecify: Whi	te
2-0	2 hours aftu "natural", dical Exar	Completed	15. Decedent's (Specify only highest of			16a. Deced	ent's Usual Occu and of work done	pation	orkina	16b. Kind	of Business/In	dustry
21	hin 72 ne. than than	E O	Elementary/Secondary (0-12)	College (1-4 or	5+)	life. Do	O NOT use retired	)	, many			
d 2	Hygie Hygie other	a l	17. Father's Name (First, Middle, Last	<u>Z</u>		Home	maker	18 Mother's N	ame (First, Middle,		1 Home	
an	be filk ental ked c	욘	Archibald Harri					1	en Collin		iriairic)	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Manyland nt of Health and Mental Hyglene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Number or F	ural Route Numbe	r, City or To	wn, State, Zip (	Code)
	d 2 stalth a n 27 is		Edgar C. Houck/H	usband		9299	Rhode Is	sland Av	enue, Col	lege	Park, 1	4D 20740
Baltimore,	permit. Page 1 and 2 signaturent of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1  Burial 2  Cremation 3	Removal from State			sition (Name of natory or other pla	ce) T-	Date	20c. Loca	ation - City or To	own, State
ij	rment tant:		4 Donation 5 Other (Special			opolit	an Crema	tory	1y 30, 2012	Alexa	ndria,	VA
Ball	permit Depar Impor any in once.		21. Signature of Funeral Service Lice	nsee		$\mathbf{F}_{\mathbf{r}}^{22}$	Name and Address J.	css of Facility Collins	Funeral	Home	Inc.	
	402.00	Н	23a. Part 1. Exter the disease, or con	molications that cause	d the ath						Spring	2. MD 20901
п	AND DAY OF THE		shock, or heart failure. List only	one cause on each lin	e.					001,		Approximate Interval Between Onset and Death
4	Medical	i	disease or condition resulting in death)	Acute  Due to (or as	on Ch	ronic	Respirat	ory Fail	Lure		-	
hough	Examiner			Cor Pu								
		Examiner	Sequentially list conditions, cause. Enter Underlying	b. Due to (or es								-
	be executed sician and burilli-transit	xam	Cause (Disease or injury that initiated events	c. End-St								
	be execut	cal E	resulting in death) Last	Due to (or as	a conseque	ence of):						
09/	physic the b	adic		d								
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XO	eath c atter	icial	in the past 12 months?  1 \( \sum \) Yes \( 2 \sum \) No	4 Pregnant a			Ectopic pregnan Other (specify)	су		20	Month	Day Year
). B	the d	hys	g 🗌 Unknown	9 🗌 Unknown			_					
P.O.	s that gned I	by F	Part II. Other significant conditions									ne cause of death?
ds,	quires en siç ould b	ted	Acute Renal Fail	ure, Atria	1 Flu	tter/	Cachycard	lia	. 1 🗆	Yes 2 🗌	No 3 ☐ Pro	bably 4 🛛 Unknown
COL	law re nas be e 2 sh	nple							24a. Was autop	osy	prior to co	psy findings available mpletion of cause of
Re	cate cate;	ပ်								rmed? 2 No	death?	2 🗆 No
ita	ician certifi rector	Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:			LOtt	Place of Death (Ch				
Division of Vital Records,	Phys r this eral di	<u>۶</u> ۲۰	27. Manner of Death	28a. Date of inju	iry 2	R/Outpatien 28b. Time of	28c. Iniu	4 ∟ Nursing rv at	Home 5 Resid			)
o u	nding ath. : After e fune	Certificate:	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigati	(Month, Da	y, Year)	injury	wor	ḱ? ] Yes 2 □ No	200.2000.00		334.734	
isic	Atter er des ector by th	artifi	3 Suicide 6 Could not 4 Homicide determine	be 200 Place of Ini			eet, factory, office		28f. Location (S		lumber or Rura	Route Number,
Οį	tal or rs aft al Dir led in			building, et	с. (ореспу)				City or Ton	ni, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate lythin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical		nysician: To the best of miner: On the basis of e								ed. use(s) and manner stated.
	the latter	Me	only one) 3 Certifying Nu 29b. Signature and title of certifier	urse Practitioner: To the	e best of m	y knowledge,	death occurred at		place, and due to t		and manner as	
	12			Mb_		M.D.	D6/	4100			Ly 27, 2	
	162		30. Name and address of person who	completed cause of o	leath (Item :							
			Smitha Bhikkaji,	MD 1500	Fores	st Gle	n Road,	Silver S	pring, M	D 209	10	
	Sta Registr		31. Date filed (Month, Day Year)	12 3. Registr	ar's Signat	ire ba	Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

Arlene Hernande		S 1- For State	tate of Ma	yland /		rtment of tificate of		nd Men	tal Hygiene	<b>J</b>	21	112	2592	
Physicia		Registrar  1. Decedent's Name (First, Midd	dle,Last)		Cert		Dealii		2. Date of De	Reg. No.	Lone V	3. Time	of Death	
Medical Exami	_		reira He	rnande	z				Month August 4	Day 1, 2012	Year	1120	) hrs	
A STATE OF THE STA		4a. Facility Name (if not instituti	on, give street ar	d number)		4	b. City, Town, o		of Death		. County of E			
		908 Erie Avenue #3	10.0			1- (-111 )	Takoma P		- Office To Date of t		Montgome		toto or	
Funeral Director		5. Social Security Number	6. Sex			st birthday)	If Under 1 Ye  Months Da		Min.	,	F	9. Birthplace (S Foreign		
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ku a		10a. State 10b. County		10	Oc. City,	Town or Locati	on						ide City Limits	
*	5	MD Mo	ontgomer	у	T	akoma 1	Park					1 🗌 Y	es 2 No	
Maryls 28a-f	Director	10e. Street and Number					10f. Zip Code			10g. Citi	izen of What	Country?		
n with the Maryland ms 23a or 28a-f show be notified at once.		908 Erie Avei					20912			US				
ath wit	Funeral	11. Marital Status  1 X Never Married 2 N	Married Arme	Decedent Eved Forces?					gin? ( Specify Yes or I , Puerto Rican, etc.)	10-	14. Race - A White, e	American India etc.	n, Black,	
", or i		_	vorced If Yes, Give		No	12	Yes 2 N	o specify:	Mexican		SpecifyWh	ite		
ours af	d b	15. Decedent's Education (Sp	or Dates:		leted)		t's Usual Docup		kind of work done	16b. I	Kind of Busin	ness/Industry		
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	Jose Pereira	s, Lasty						Eulalia He					
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "matural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relation				_	,	eet ano Nun	nber or Rural Route N	Number, City or Town, State, Zip Code)				
MD d 2 sh lih and n 27 is		Adalia Goycoch	nea/Sist	er 	1				ive, Silve			MD 2090 ity or Town, Sta		
ore, an of Heal		20a. Method of Disposition  1 Burial 2 Crematic	on 3 Remov	al from State	20b. P	rematory or oth	tion (Name of c per place) tan rematory	emetery,	Aug. 13		Location - Ci	ity or Town, Sta	ite	
Baltimore, permit. Pages la Department of He important: If ite		4 Donation 5 Other S			1100	Lopor	rematory	y on of Conility	2012			lria, V	A	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		21 Signature of Funeral Service	Later			Fra	ancis J.	. Col	ins Funer Blvd. W.,	al Ho	ome In	ic.	MD 2090	
Physician		23a. Part I. Enter the disease, of	or complications the	nat caused th	e death.	Do not enter the	ne mode of dying	g, such as c	ardiac or respiratory a	rrest, sho	ock, or heart	Approx	cimate Interval	
/Wedical		failure. List only one cause on each line.  Immediate Cause (Final disease a.Narcotic and Alcohol Intoxication Between Onset and Death												
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ecuted and and transit		events resulting in death) Last	d.	as a conseq	derice or,	<i>).</i>								
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Box 68760, edath certificate be the attending physical for use as the bur	3	IF FEMALE: 23b, Was decedent pregnant in	Alma Com	es, outcome	of pregn		al death 3	Ectopia	c pregnancy	230	d. Date of de Month	elivery Day	Year	
C 68 1 certif ending use as	cian	past 12 months?	4 P	regnant at tir	ne of dea		aldeath 3 ner (Specify)	Естори	c pregnancy		MOUNT	Day	Teal	
Boy e death the att	Physi	1 Yes 2 No 9 V U	3	Inknown										
s, P.O. B uires that the d signed by the	by P	Part II. Other significant cond	itions contributi	ng to death b	out not re	sulting in the u	nderlying cause	given in Pa			_	re to the cause	_	
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COTC law re has be	Completed								per	opsy form <u>ed</u> ?	dea			
Rec: The liftcate liftcate l		25. Was case referred to medic	al C	···			26 Plac	re of Death	(Check only one)	2N	0 1	Yes	2 No	
/ital sician	Be c	examiner?	Hospital: 1	Inpatient	2	ER/Outpatient		-	Nursing Home 5	Reside	ence 6 🗸	Other Scene		
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ion ttendii tor: /	atio		nding estigation <b>f</b> d	8-4-1	L2	fd11:0	JU am	Yes 2 🗶						
Division ra or Attendii rs after death. al Director: Aled in by the fu	Certification:	3 Suicide 6 X Co	uld not be 28e.			me, farm, stree t <b>home</b>	et, factory, office	building, et	or Town	State) 9	08 Eri	or Rural Route Le Ave.		
Division of Vital Records, P.O. Box 68760 within 24 hours after death.  To the Bospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu		4 Homicide					red at the time,	date and pla	Takoma ace, and due to the ca			s stated		
To the within 2 To the complet	Medical	one) 2 Medical Ex	aminer: On the ba				ion, in my opinio	on, death oc	ccurred at the time, da	te and pla	ace, and due	to the cause(s		
	Ž	29b. Signature and title of certif	ier 1	11				nse number			Date signed gust 5, 20	(Month, Day,)	rear)	
5PEND		<u> </u>	NVI.	IN	-4b (1)	22-1		,.IVI. □.		Aug	Just 0, 20			
		30. Name and address of person Jack Titus MD. De					Baltimore St	reet, Balt	timore, MD 2122	3				
	ate	31. Date filed (Month Cay Year	2012	2 Registrar's	Signatur	. bar	es.							
Regist	TGU			MARKET STATE	- 10									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				For State Registrar	State of Ma	ryiano	-	artment of I tificate of I		and Menta	l Hygier Reg. l	201	2 25921
		Physicia	n/	1. Decedent's Name (First, Middle, La	,					2. Date Mon	of Death	Day Year	3. Time of Death
4		Medic Examin		Dr. Kenneth Henn 4a. Facility Name (if not institution, giv	e street and number)	<u>n Jr</u> /		4b. City, Town, 9	r Location			4c. County of Dea	2 5118 AM
	<i></i>	-			Ce A+ the V	-ak	e at histogram	Salisk If Under 1 Year	URC	4	6	Willow	IND
		Funeral Director		577-28-8310	1 X M 2 □ F 88		st birthday) Yrs.	Months Days	Hours		of Birth th, Day, Year I 1924	4 Wes	rthplace (State or Foreign buntry) t Virginia
		and show at	or	Usual Residence of Decedent  10a. State  10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
		Maryla 28a-f s otified	Director	Maryland Wicomico		Hebi	ron						1 🗆 Yes 2 🙀 No
	;	ith the 23a or st be n	ral D	10e. Street and Number 7786 Quantico Ro	bec			10f. Zip Code 21830				Citizen of What C	ountry?
	:	leath w items ; er mus	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	. 13.		ispanic Or	igin? (Specify Yes on, Puerto Rican, et	USA or No-	14. Race - Amo	erican Indian,
	36	e filed within 72 hours after death with the Maryland Ital Hygiene. And other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 N If Yes, Give Year or Dates. N			r yes, specify Cuba			C.)	Black, Whit	
	2-0	2 hours "natur dical E	plete	15. Decedent's I (Specify only highest g.	Education	avy	16a. Deced	dent's Usual Occup	ation	at of working	16b.	. Kind of Business	nite Industry
	21215-0036	led within 72 Hygiene. other than ent, the Me	Completed by	Elementary/Seconday (0-12)	College (1-4 or 5+	)	life. D	intendani		st or working			
	nd 2	filed wall Hygi dothe	Be	17. Father's Name (First, Middle, Last)			buper	Incendan		ner's Name (First, M		ducation en Surname)	
	Maryland	d Ment marker natic e	오	Kenneth Henning H						e Kite			
	Z a	permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, the once.	1	19a. Informant's Name/Relationship ( Bonnie Hildreth   w			1.			er or Rural Route N Hebron , N			'
3	Baltimore,	ge 1 and t of Hear If item or othe		20a. Method of Disposition 1  Burial 2  Cremation /3		се	ace of Dispo emetery, cren	sition (Name of natory or other place	ce)	Date		Location - City or	
XVI ICA	ltim	nit. Pag artmen ortant: injury i		4 ☐ Donation 5 ☐ Other Spec 21. Sign Jure of F	ify)	Sal		Cremato		07   27   201		lisbury,	Maryland
	Ba	Imp any onc		VIK HOLO	e CES	P	Ħ   5	olloway 1 01 Snow 1	uner Hill	al Home E Rd., Sali	A. sbury	, Marvla	nd 21804
Œ.				23a. Part 1. Enter the disease, or conshock, or heart failure. List only	one cause on each line.				g, such as	cardiac or respirat	ory arrest,		Approximate Interval Between
4	P	hysician Medical	1	Immediate Cause (Final disease or condition resulting in death)	a. Dan  Due to (or as a of		) T   G						Onset and Death
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Y	760	physician and the burial-transit		that initiated events resulting in death) Last	C. Due to (or as a c	conseque	ence of):						
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				IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnan	icy	Fotonio prognasa				23d. Date of de	livery
	ision of Vital Records, P.O. Box 68	the att	Physician/M	in the past 12 months? 1 ☐ Yes ☐ No 9 ☐ Unknown	4 Pregnant at t	ime of de		Other (specify)	, у	•		Month	Day Year
	P.O.	been signed by the should be detached	by Ph	Part II. Other significant conditions	contributing to death but	not resu	Ilting in the u	nderlying cause giv	en in Part	I. 23e.	Did tobacco	use contribute to	the cause of death?
	rds,	een sig	eted								1 🗆 Yes	2 PRO 3 □ P	robably 4 🗆 Unknown
	Division of Vital Records,	e has b	Completed							24a.	Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
	<u>a</u>	s certificate has b lirector, page 2 s		25. Was case referred to medical examiner?				26. PI	ace of Dea	1 L	Yes A	No 1 ☐ Yes	s 2/€#R6
		this ce	၉	1 Yes 2 No	Hospital: 1 Inpatien 28a. Date of injury		R/Outpatien		4 LI N	ursing Home 5			ity HOSPICE
	o uo	ath. Ir: After	icate	Natural 5 Pending 2 Accident Investigatio	(Month, Day, '	Year) '	injury	28c. Injury work M 1 🗆	/at ? Yes 2 □	į.	cribe how inj	ury occurred	
	IVISI	after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined		- At hon Specify)	ne, farm, stre	et, factory, office			tion (Street a or Town, Sta		ral Route Number,
	Div	hours hours uneral	Medical	29a. Certifier Certifying Phy	vsician: To the best of m	y knowle	dge, death o	ccured at the time	, date and	place, and due to t	he cause(s)	and manner as sta	ated.
	t at	within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director.	Mec	(Check 2 Medical Examonly one) 3 Certifying Nur  29b. Signature and title of certifier	rse Practioner: To the be	mination est of my	and/or invest knowledge, o	eath occurred at the	e time, date	ccurred at the time, and place, and du	to the cause	e(s) and manner as	
4	٩	- > <b>-</b> > 0		200. Orginator o and three of Certifier	_			29c. License	5 X	110	29d. D	Date signed (Mont) $\frac{7}{23}$	n, Day, Year)
1		DIC		30. Name and address of person who	completed cause of dea	th (Item 2	23a) (Type, P	rint)	( )			11-11	120 -
1		Stat	e	31. Date filed (Month, Day, Year)	32 Registrar's	Signatu		1775	SAC	y Bul	y u	10 cm	100 -
		Registra		JUL 30 20	12 agrana	-	1	Med					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death , <u>2012</u> Physician/ a Roy Holmes <u>July 23</u> 2:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Wicomico 7419 Cherry Walk Road Hebron 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 $\square$ F Hours Months Days (Month, Day, Year) 02/10/1929 Yrs 254-46-3278 83 Director North Carolina Usual Residence of Decedent 28a-f shov 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director must be notified 1 Tes 2 X No Maryland Wicomico Hebron 5 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 23a Funeral with 21830 7419 Cherry Walk Road USA al Hygiene. d other than "natural", or items event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 ☐ No If Yes, Give Year or Date AirForce Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Air Force <u>Tech Sat</u> event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic even ၉ Louie Jane Johnson Boyd Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 7419 Cherry Walk Rd., Hebron, MD 21830 Barbara J. Holmes/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 0.10 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: It any in ...y or once. 7/24/2012 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Salisbury Crematory Spinature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 2024. Rompson 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition hronne Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the atte Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۵ Completed 1XYes 2 No 3 Probabiy 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy perform Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation

Division of Vital Records, P.O. Box 68760

2 IVA State

the

within 24 hours after death.

To the Funeral Director: A completed filled in by Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 License number 29d. Date signed (Month, Day, Year, address of person who completed cause of death (Item 23a) (Type, Pri

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

of death (Item 23a) (Type, Print)
(GASTAL HOSPILE POBOX1733) egistrar's Signatu

6 Could not be

30

determined

Suicide

4 Homicide

29a. Certifier

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2012 0935 АМ Martin William Helsel August Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 Singerly Manor Assisted Living E1kton 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Funeral July 23 Pennsylvania 1 X M 2 🗆 Hours 1932 80 Director 213-26-0629 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Ceci1 E1kton 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral United States 21921 305 Skipjack Court death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1952 1  $\cancel{X}$  Yes 2  $\square$  No If Yes, Give 19514. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married \$ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: 1954 Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16b Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r Automobile Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Assembler Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel Mildred Good Lincoln E. Helsel other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shan Department of Health an Important: If item 27 is any injury or other traus 183 Ricketts Mill Road, Elkton, MD Chris N. Norman/Daughter 20b. Place of Disposition (Name of Immatery Transferry or other place)
Conception Cemetery 20a. Method of Disposition 20c, Location - City or Town, State August 8 1 Burial 2 Cremation 3 Removal from State Cherry Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signa re of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIOM. Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate
Enter Inderlying
Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death been signed by the s should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s autopsy performed Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Așsisted Other: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 🎇 Other (Specify) မှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? . Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 1. Norge D0065733 MD ०४ e7

State Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

E. 4764

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V- PULA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arunde1 Anne Harwood Mandrin Hospice House If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, You 1 1 Days Hours Maryland Director 203-24-8477 1**X** M 2 □ F 78 Yrs. May 1934 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov 10b. County filed within 72 hours after death with the Maryland al Hygiene. or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Annapolis Anne Arundel Mary1and 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 21403 1340 Fishing Creek Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces: 1 X Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: **Black** 3 Widowed 4 Divorced Year or Dates 1 9 5 1 - 5 3 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United States Page 1 and 2 should be filed within 73 nent of Health and Mental Hygiene, ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Naval Academy 9th Painter or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruby Jefferson Bartimus Jayson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Jayson(Wife) 349 Fishing Creek Rd. Annapolis, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date maryland Veteran 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. Crownsville, Md. 7-30-12 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Winname Recorded GaciliSons Mortuary, P.A. 21401 1922 Forest Dr. Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1 Ne man Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending obvisician and been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 No 1 🗆 Yes 2 🗆 No completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manual of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar 1. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item-23a) (Type, Print)

30

1777

30/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Craig Johnson 03:20 BW 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 MM 2□F Days Hours 577-80-0201 **Director** 55 Nov. 27,1956 Ohio Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No "natural", or Items 23a or 28a-f s idical Examiner must be notified Directo Maryland Charles Waldorf 10f. Zip-Code 10e. Street and Number 10g. Citizen of What Country? 3217 Nobility Court Funeral 20603 United States Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify If Yes, Give þ Specify: Black 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) IT Specialist <u>Freddie Mac</u> 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Louise Hailes 2 James R. Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3217 Nobility Court, Waldorf, Maryland 20603 <u>Lisa B. Johnson/Wife</u> 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or Resurrection Cemetery 07/31/2012 Clinton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Icn. 7400 Georgia Avenue, North West Washington, District of Columbia 20012 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): hemorrhage disease or condition resulting in death) /Medical Examiner Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last colun Examiner Due to (or as a consequence of e attending physician and The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 2 No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? 1 ✓ Yes 2 ☐ No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ٩ O completely filled in by the funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division ( Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) To the Hospital or within 24 hours a To the Funeral D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number

DHMH 17 Rev 1/2001 11595

State Registrar

Ocme

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registra

31. Date filed (Month, Day, Year)

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24,2012

July

4940 Eastern Avenue, Baltimore, MD, 21224

	nđ #4C pe Cb. Healt		try. 7/31/2012 Please Type or Print in Black Ir				ole.
		1	State of Maryland / Department	artment of F <i>tificate of L</i>		Hygiene 20	12 25929
	Physicia		1. Decedent's Name (First, Middle, Last)  Ruth D. Kominicki		2. Date of Month		3. Time of Death
-	Medic Examin		4a. Facility Name (if not institution, give street and number)		r Location of Death	4c. County of	
.£			Anne Arunael Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Annapo If Under 1 Year	If Under 24 Hrs. 8. Date of	Arne Aru	Birthplace State or Foreign
	Funeral Director		$\begin{array}{c c} 0.350 \text{ as Security National } \\ 0.25-12-7826 \\ 1 \square \text{ M 2 M F} \\ 90 \\ \text{Yrs.} \end{array}$	Months Days	Hours Min. (Mont	h, Day, Year)	Country) lassachusetts
	ind show at	'n	Usual Residence of Decedent  10a, State 10b. County 10c, City, Town or Lo	cation			10d. Inside City Limits
	Maryla 28a-f s otified	irect	Maryland Prince George's Bowie	Tarana			YXX Yes 2 □ No
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 12223 Marne Lane	10f. Zip Code 207	15	10g. Citizen of What U. S.	
	death \		Armed Forces?	Nas Decedent of H f Yes, specify Cuba	lispanic Origin? (Specify Yes o an, Mexican, Puerto Rican, etc		American Indian, White, etc.
036	rs after rral", or Exami	ed by	1 Never Married 2 Married  1 Yes 2 No If Yes, Give Year or Dates. 1943-45	1 ☐ Yes 2 🎇 No	Specify:	Specify:	White
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212	within 7 giene. er than , the Me	Con	Elementany/Secondary (0-12) College (1-4 or 5+)	es Person		Retail	
and	oe filed ental Hy ced oth c event	To Be	17. Father's Name (First, Middle, Last)  Frank B. Dunn		18. Mother's Name (First, Mi Catherine (	iddle, Maiden Surname) Conley	
Maryland	12 should be filed within 7 lith and Mental Hygiene. 27 is marked other than r traumatic event, the M		19a. Informant's Name/Relationship (Type, Print) Patricia Clunies/Daughter 12223	ng Address (Street Marne L	and Number or Rural Route N ane, Bowie, Ma	umber, City or Town, Stateryland 207	te, Zip Code) 715
	1 and of Hea item othe	- 1	20a. Method of Disposition 1  Burial 2  Cremation 3  Removal from State	osition (Name of matory or other place	ce) Date	20c. Location - C	ity or Town, State
Baltimore,	Par India		4 Donation 5 Other (Specify) Huntt Cr	ematory	7/24/2012 ess of Facility Robert I		Maryland
Bal	permit. Departr Imports any inju	3			apolis Road, l		
ľ			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			ory arrest,	Approximate Interval Between Onset and Death
đ	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)  a.   Multi-cr an  Due to (or as a conservence of):	lem tai	lure		
	Examiner	e.	Sequentially list conditions, b. Due to or as a consequence of				2 days
	ecuted and Il-transit	Examiner	Cause (Disease or injury that initiated events	insection			2 days
_	oe ex <b>e</b> cut ician and burial-tra	_	resulting in death) Last Due to (or as a consequence of):				
8760	ificate be exe ng physician as the burial	Medic	IF FEMALE:				
Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be ex thin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician mpletely filled in by the funeral director, page 2 should be detached for use as the buria	Completed by Physician/Medical	23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 Live Birth 2 Fetal death 3	Ectopic pregnan Other (specify)	ncy	23d. Date Mont	
O. B	es that the dea signed by the a be detached t	Physi	9 Unknown	undorhijng oguno o	ilyon in Port I	Did to be one upo contrib	oute to the cause of death?
s, P.O.	res that signed d be de	d by	Part II. Other significant conditions contributing to death but not resulting in the	andenying cause g	239.		B ☐ Probably 4 ☐ Unknown
ord	w requires ts been sig 2 should b	plete	,		24a	autopsy pri	ere autopsy findings available ior to completion of cause of
Rec	sician: The law is certificate has the director, page 2 s		25. Was case referred to medical		1 Place of Death (Check only one	Yes 2 No 1	eath?  Yes 2 No
Vital	ysician s certif directo	o Be	examiner? 1   Yes 2   No   Hospital: 1   Impatient 2   ER/Outpatie	LON	her: 4 Nursing Home 5		(Specify)
Division of Vital Records,	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certificate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) injury	wor	rry at 28d. Deserrik? ☑ Yes 2 ☐ No	cribe how injury occurred	1
ision	f or Attendi after death. Director: A d in by the fi	artific	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Loca	ation (Street and Number or Town, State)	or Rural Route Number,
Ω	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the tir			r as stated.
	he Hos in 24 hc he Fun pletely	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my onin	nion, death occurred at the time.	date and place, and due t lue to the cause(s) and ma	to the cause(s) and manner stated.  Inner as stated.
	<b>७</b> ₹ <b>७</b> 8		29b. Signature and title of certifier		se number 073920	29d. Date signed (	(Month, Day, Year)
	1641		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
			Patricia Plan, MD 2001 Medit.  31. Date filed (Month, Day, Year) 1 2012 32. Registrar's Signature 1.	cal Par	Eway, Annap	olis MD 214	01
	Sta Registi		31. Date filed (Month, Day, Year) 1 2012 32. Fegistrar's Signature 32. July 31 2012	Janes -			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 30 Physician/ KIKER 315 LULINE AM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Brightview South River Edgewater Anne Arundel Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Davs Hours Min Director 241-09-3250 93 1 □ M 2 🗓 F Yrs 08/10/1918 NC Usual Residence of Decede 23a or 28a-f show 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2XX No MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8 Lee Airpark 21037 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 □ Divorced White and Mental Hygiene.

Is marked other than "naturraumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Mill worker Hosiery Mill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Mullis Lula Louise Kepley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health Rita Bloom (daughter) 59 Decature Ave. Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carolina Mem. Park 8/2/2012 Kannapolis, NC 21. Signature of Funeral Service Leansee 22. Name and Address of Facility Hardesty Funeral Home Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ONGESTIVE r aurs Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician by Physician/Medical Hospital or Attenting Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Ectopic pregnancy for Other (specify) Month Day Year Pregnant at time of death ☐ Yes ☐. ☐ Unknown Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? signe 1 be G NOLLINAAL 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? DEPRESSION 24a, Was an autopsy performed? Yes 2 N page 2 DEMENTIA this certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural 2 Accident injury 5 Pending a er death Director: A d in by the f Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours at To the Funeral Discompletely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

HERSH

JUL 31 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

29c. License number

445

P0036591

HOSPICE OF THE

DEFENSE

29d. Date signed (Month, Day, Year)

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CHESAPEAKE

MUNA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month Physician/ 2012 Medical **Examiner** HESTERIO 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 414-60-6022 1 **X**M 2 □ F 04/25/2012 72 Tennessee Usual Residence of Deced 28a-f shov 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 XNo MD Queen Anne's Chestertown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò Funeral 23a 21620 6744 Church Hill Road United States Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iterr ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give 3 Widowed 4 Divorced Completed White Year or Dates. 1958-64 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Superintendent 12 of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Helen Henderson Luke King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is or other tra 3506 Christianna Court Cheasapeake Beach, MD 20732 Michael King / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State Department o Important: If any injury or Chesapeake Cremation 07/27/2012 Stevensville, Maryland 4 Donation 5 Other (Specify) Signature of Juneral Service L Fellows, Helfenbein & Newnam Funeral Home, 130 Speer Road Chestertown, Maryland 21620 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Approximate Interval Between Onset and Death aused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ organ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami Cour Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) detached for in the past 12 months? Day Month Year 2 No the 9 Unknown 9 Unknown þ eath but not resulting in the underlying cause given in Part I. Part II. Other significant conditions on tributing to 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No Probably 4 - Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28c. Injury at Manner of Death 28a 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the within To the 29d. Date signed (Month, Day, Year) 9 dicause of death (Item 23a) (Type, Print) address of person who comple 00 enlown and Brown Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Catherine Leonard Kapp Medical Julv2012 1:40 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3126 Gracefield Road, BG 218 Silver Spring Montgomery 5. Social Security Number Funeral 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 094-26-5306 Days Hours Min. (Month, Day, Year) Director 1 □ M 2 🖺 F 78 March 9, 1934 Usual Residence of Decede ir then "naturel", or Items 23a or 28a-f show the Medical Examirer must be retified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No MD Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3126 Gracefield Road, BG 218 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 ☒No If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiens Importent: if Item 27 is merked other then eny Injury or other treumatic Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas E. Leonard Viola B. Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip A. Kapp/Husband 3126 Gracefield Road, BG 218, Silver Spring, MD 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition resulting in death) yrs Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami ettending physician and for use es the buridistransi requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Dav is certificate hes been signed by the director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Lung Carcinoma Completed 1 ₺ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours effect death.

To the Funeral Director: Affer this certificate h completely filled in by the funeral director, page ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🖾 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) ca 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of 29b. Signa certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D24035 July 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, MD 20904 Eugenio Machado, MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

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P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #30. per DVR, 9930 8-14-12 sm
State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AWGUST 20 Year 7:55A M KLOPFER Medical EDWIN SR NHOL 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLOTTE HALL VETERANS HOME CHARLOTTE HALL MARY'S Sex 1XIXM 2 □ F 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Months Hours DEC. 31, 1928 WASH., DC 579-30-2819 83 **Director** Usual Residence of Decedent show or 28a-f shove oe notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD CHARLES LA PLATA 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? pe i 23a Funeral must 18 PARTRIDGE COURT 20646 S. Α. 2 should be filed within remain and Mental Hygiene.
27 is marked other than "natural", or items
27 is marked other than "natural", or items death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No þ Maryland 21215-0036 1 Yes 2 No Specify. If Yes. Give 3 Widowed 4 Divorced Year or Dates: 51- 53 Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SELF-EMPLOYED SETTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic CHARLES KLOPFER ANN MURDOCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOLORES E. KLOPFER/WIFE 18 PARTRIDGE CT., LA PLATA, MD 20646 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition AUGUS® 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State ST. IGNATIUS CH. CEM. 8,2012 CHAPEL PT., MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 20646 M00641 WASHINGTON AVE MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line MEUMONIA RIGHTWAGELODE Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to force a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last certificate be executed and-tran Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months? 5 Other (specify) Pregnant at time of death g Unknown Division of Vital Records, P.O. ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed EREDROVASCULAR ACCIDENT 24b. Were autopsy findings available 24a, Was an ate has bage 2 s autopsy performed? prior to completion of cause of MARONIC OBSTRUCTIVE PULMONARY DISGASE 1 Yes 2 No After this certificate To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Dav. Year) 29b. Signatur 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Stephen Cafferty 22333 Greenview Pkwy Unit 5A Great Mills, MD, 20634

32. Registrar's #gnature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Taylor Alexis L		State of Maryland / Depart	ficate of Death		2012 259
hysician/ Medi		Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
Exam	iner	Taylor Alexis Lewis		July 26, 201	12 1635 hrs
		Facility Name (if not institution, give street and number)     Peninsula Regional Medical Center	4b. City, Town, or Location of De Salisbury	ath	4c. County of Death Wicomico
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		220-57-0420 1 M 2KF 12		vin. 7/4/2	Country)
		Usual Residence of Decedent		1 / 1 / 2	
v any		10a. State 10b. County 10c City, To	own or Location		10d. Inside City Limits
Maryland 282-f show	jo		llards		1 Yes 2 No
he Mary or 28a	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
ith the		7234 State St.  11. Marital Status 12. Was Decedent Ever in U.S.	21874  13. Was Decedent of Hispanic Origin? (	Specify Yes or No-	USA  14. Race - American Indian, Black,
eath w items	Funeral	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	White, etc.
after d	by Ft	3 Widowed 4 Divorced If Yes, Give Year or Dates'	1 Yes 2 No specify:		Specify: white
hours af "natural		15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind o during most of working life. DO NOT use r		16b. Kind of Business/Industry
36 thin 721 them "u	mpleted	Elementary/Secondary (0-12) College (1-4 or 5+)	7/7		n/a
5-0036 led within 72 Etygiene. other than	Com	6 17. Father's Name (First, Middle, Last)	n/a 18.Mother's Na	me (First, Middle, Mai	
21215-0036 buld be filed within 7 Mental Hygiene, marked other than ic event, in Media	Be	Edward Ruben Lewis	Abb.	i Lee Sc	human
221 hould in Mel	ပ္	19a. Informant's Name/Relationship (Type, Print )			er, City or Town, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiewith minoritant of Health and Mental Hygiewith than "natural", or items 23a or 23a-f shi important: If term 27 is marked other than "natural", or items 23a or 23a-f shi injury or other traumatic event, the Medical Examinations to confired at once		Edward R. Lewis / father  20a Method of Disposition	7234 Sate St., W.		MD 218/4 20c. Location - City or Town, State
Baltimore, permit Pages 1 ar Department of Hee Important: If the injury or other tr		1 XBurial 2 Cremation 3 Removal from State cre	ematory or other place)		
ltim it. Par rumen ortant		4 Donation 5 Other Specify Dall 21. Signature of Fundal Service Licenses	e Cemetery 7, 22. Name and Address of Facility	/29/12	Whaleyville, MD
Da Perm Depa Imp		W. Tril Bulas.	108 William S	t., Berl	in, MD 21811
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.			
/Medical Examiner		Immediate Cause (Final disease a gunshot wound of head			Death
		or condition resulting in death)  Due to (or as a consequence of):			
	Jer.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated country resulting in death). Last Due to (or as a consequence of).			
ecuted and transit		events resulting in death) Last Due to (or as a consequence or).			
an an	dicai	UNPENDED AMENDED			
	/Medi	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth	ncy 2 Fetal death 3 Ectopic pre	ananau	23d. Date of delivery  Month Day Year
Box 68 death certif the attending	clar	4 Pregnant at time of death		griditey	Montal Day (Val
Box 68.  In death certification the attending red for use as 1	Physiciar	1 Yes 2 No 9 Unknown 9 Unknown			
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S, F quires en sign uld be				24a. Was an	
cords, law requir has been s	Completed			autopsy perform	prior to completion of cause of death?
tal Rection: The certificate ector, page		25, Was case referred to medical	26 Place of Death (Che	1 X Yes 2	No 1 X Yes 2 No
of Vital Records, gPhysician: The law require this certificate has been sineral director, page 2 should be need to be a second to the second t	Be	examiner? Hospital 1 Inpatient 2 V E	Other		esidence 6 Other:
of \ ing Phy After th tuneral o	<u>ار</u>	27 Manner of Death 28a, Date of Injury 2	8b. Time of Injury 28c. Injury at Work?	1	w injury occurred
ion tendii eath. tor: A	ation		FOUND: 1 Yes 2 No	Subject shot	
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ospita hours neral		29a Certifier 27 a (17) District Tally to the following		7234 States S	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certiful to the Runeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	dical	one) 2 Medical Examiner: On the basis of examination and/			
To To con	Medi	29b. Signature and title of certifier	29c, License number		29d. Date signed (Month, Day, Year)
		The fee It have The	O.C.M.E.	OCME	July 27, 2012
		30 Name and address of person who completed cause of death (Item 23)			000
ET	1	Theodore M. King, Jr., MD. Assistant Medical Exa  31 Date filed (Month, Day, Year)  32 Registrar's Signature,		Baltimore, MD 21	223
S Regis	tate trar	JUL 3 0 2012 Access A	parker		
DHMH 17 Per 1/2	204		ORIGINAL		

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

n/	Registrar  1. Decedent's Name Narvie	(First, Middle, La	,						2. Date of De Month		/ Year	3. Time of Death 2 0736 A M
al er	4a. Facility Name (if	not institution, giv	e street and number) dventist	Hogn	i + o 1	4b. City, T	Town, or I	ocation of Death	<u>  July</u>			Montgomery George's
	5. Social Security No.	ımber 6.	Sex 7. Ag	e (In yrs. las		If Under Months		If Under 24 Hrs Hours Min.	8. Date of Bir	rth	9. Birth	-place Otate on Femily
or	Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Loc	ation						10d. Inside City Limits
Director	MD		e George'	s H	yatts	_						1 🔀 Yes 2 🗆 N
Funeral	10e. Street and Nun 5848 33		ce			10f. Zip	2078	2		10g. Citi	zen of What Cou US	
þ	11. Marital Status 1 ☐ Never Marri 3 <b>X</b> ] Widowed	ed 2  Married	12. Was Decedent I Armed Forces? 1. U Yes 2 U If Yes, Give Year or Dates.	194	13- If		fy Cuban	panic Origin? (Sp., Mexican, Puert			14. Race - Ameri Black, White, Specify: B1	
completed	(Spe	15. Decedent's cify only highest g	ducation		16a. Decede		done du	tion uring most of wo	rking	16b. Kii	nd of Business Ir	ndustry
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o pe	17. Father's Name (I	First, Middle, Last) Wiley	Larry					18. Mother's Na	ne <i>(First, Middle,</i> attie		<sub>Surname)</sub> eman	
	19a. Informant's Na Edward										Town, State, Zip D 2078	
			Removal from State	ce	netery, crements Me	em. E	her place Park	8/2	Date / 2012	Gol	dsboro	, NC
	21. Signature of Fur	neral Service Licer	riscoe -	Tone							c Fune ldorf,	ral Home MD 2060
ical Examiner	Immediate Cause (disease or condition resulting in death)  Sequentially list configure in the configure in cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nditions, mediate lying injury	a. Due to (or as a Due to (or a) Due t	a conseque a conseque	ence of):	diove	عادسا	lar dis	ease			Onset and Death
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Completed by									24a. Was	an	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
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<u>۱</u>	1 Yes 2 27. Manner of Death 1 Natural 2 Accident		28a. Date of inju (Month, Day	irv 2	R/Outpatient 28b. Time of injury		Bc. Injury work?	4 □ Nursing F at	dome 5 Resi		Other (Specificocourred	<u>-</u> _
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I Certificate:		- · · · · · · · · · · · · · · · · · · ·	ysician: To the best of		and/or investi	gation, in m	ny opinior	, death occurred	at the time, date	and place,	and due to the ca	ause(s) and manner stat
Medical Certificate	(Check 2 only one) 3	☐ Medical Exar ☐ Certifying Nu	rse Practioner: To the	best of my l	Kilowieuge, u							
	(Check 2	☐ Medical Exar ☐ Certifying Nu		best of my	Kriowiedge, di		License				e signed (Month,	Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HAROLD VERNON LEWIS, SR. 2:15 PM TULY 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LA PLATA CHARLES CENTER WISTA MEDICAL If Under 24 Hrs **Funeral**  Birthplace (State or Foreign Country) (Month, Day, Year) Days Hours 214-28-2642 Director 1 X M 2 D F 78 MARCH 22, 1934 MARYLAND Usual Residence of Dec 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD CHARLES **NANJEMOY** 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code ms 23a o must be 10g. Citizen of What Country? Funeral 7960 GILROY ROAD 20662 UNITED STATES 11 Marital Status Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 2 X No 1 Yes Maryland 21215-0036 1 Yes 2X No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: Year or Dates BLACK the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) PRINCE GEORGES BOARD OF EDUCATION College (1-4 or 5+) **ENGINEERMAN** Ith and Mental Hygie 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame ည JAMES ALFRED LEWIS DOROTHY ANN WILKERSON LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a HENRY VANDYKE LEWIS/BROTHER 7960 GILROY ROAD, NANJEMOY, MD 20662 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If i any injury or conce. 1ื Burial 2 🗌 Cremation 3 🔲 Removal from State HOPE CH. CEMETERY 08/02/2012 MT. NANJEMOY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servoy, Licenson

LYDIA C. THORNION JOHNSON MO0583 THORNTON FINERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ nation disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Orderlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic preonancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month signed by the at d be detached for 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Jas performed certificate Yes 2 No 1 Yes 2 Woo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Xinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending 10 Natural 5 Pending Accident Suicide 1 Yes 2 No the 1 Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 28 1300 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 579-20-7374 1 - M 2 X F Director 89 Feb. 15, 1923 Italy ir than "natural", or items 23a or 28a-f shov the Medical Evanniner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Davidsonville 1 X Yes 2 No Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1054 Ashe Street 21035 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ۵. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 to Health and Mental Hygiene.
If item 27 is marked other than "nor other traumatic event, the Mod Elementary/Secondary (0-12) College (1-4 or 5+) Nurses Aide Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, စ Rocco DiGirolamo Ermenia Saraceni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2214 Fleming Lane Bowie, MD 20715 Anthony Marconi/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemtery 8/2/2012 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Septica Lice 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final aclu Physician disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The lew requires that the death certificate be executed siclan and burial-trans Due to (or as a consequence of): resulting in death) Last physiclan Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown ō Day detached the g 🗌 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Corona 2 No 3 Probably 4 Unknown been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an las l autopsy within 24 hours after death.

No the Funeral Director: After this certificate to completely filled in by the funeral director, page Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 P No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 30/12 20 10 30. Name and address of person who of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month<sup>-1</sup> Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Heritage Harbour Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 068-34-0854 93 Director 1 🗆 M 2424 F 10/22/1918 NY ital Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Experiment rust be a office at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Annapolis Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 USA 820 Midship Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Manital Status Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 🏋 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify. 3 Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ည Sophi Klenczon Stanley Mierzejewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 820 Midship Ct. Annapolis, Md 21401 daughter Barbara Leonard 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Burial 2 K Cremation 3 ☐ Removal from State 7/27/2012 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Facility</sup> Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 21. Signature of Funeral Service Libensee 12 Ridgely Ave. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or Approximate Interval Betw shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ e air EMENTI Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and ched for use as the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by SWDOMONKS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 🛮 Nursing Home 5 🗀 Residence 6 🗀 Other (Specify) 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 26, 2012 4:40 PM JOSEPHINE MONROE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CHESTERTOWN KENT CHESTER RIVER HOSPITAL CENTER 8. Date of Birth (Month, Day, Year) Oct. 5, 1956 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. Social Security Number Months Days Hours Min. 212-70-2340 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 XNo MILLINGTON KENT 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 21651 120 SPRING ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify If Yes, Give Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) CLOTHING College (1-4 or 5+) Elementary/Seconday (0-12) MANUFACTURING ASSEMBLY PERSON 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) AREZELIA VIRGINIA MASSEY WALTER KENNEDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 SPRING ROAD, MILLINGTON, MD 21651 ROBERT MONROE/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XBurial 2 Cremation 3 Removal from State MILLINGTON, MARYLAND GRAVES CHAPEL CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility.
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
370 W. CYPRESS ST. MILLINGTON, MARYLAND 21651 of Funeral Service 23a. Part 1. Enter the diseast shock, of beart failure Approximate Interval Between Onset and Death the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. Immediate Cause (Final Myoundia disease or condition resulting in death) Sequentially list conditions, Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ Year Month Day Pregnant at time of death

Physician/ Medical **Examiner** 

Physician/

Medical

10a. State

MD

21. Signatur

Examiner

**Funeral** 

Director

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t of Healt ; If item ? or other

Important; If any injury or once,

the Medical

Page 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

must be notified at

Director

Funeral

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Completed

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Examine

Be Completed by Physician/Medical

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Certificate:

Medical

use as the burial-trar physician ò signed by the a page 2 hin 24 hours after death. the Funeral Director; Aft upleted filled in by the fur

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death (Check only one) 27. M

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 🔲 Yes

Yes 2 No	Hospital: 1  Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing F	lome 5 Residence 6 Other (Special
anner of Death  Natural 5 Pending Pending Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) MO 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FREDERICK DELBOY, M.D., 6602 CHURCH HILL RD, SUITE 200, CHESTERTOWN, MD 21620

State Registrar

within 2

To the F

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0225A M Rosalee Marshall Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NICOMICO REGIONAL TENINSULA Medical SAL156411 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 214-28-8551 1 □ M 2 🛛 F 79 -23-1933 DE or 28e-f shov Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f sho any injury or other treumatic event, the Modical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 XNo DE Sussex Delmar 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 203 Bynum Lane 19940 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. <u>م</u> 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 SpeciBlack 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 9 <u> Housewife</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Robert Bynum Sarah Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Marshall/Son 10303 Fawn Rd, Greenwood, DE 19950 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placem 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Israel Memorial 7-28-2012 Princess Anne, Signature of Buneral Service Licensee 22. Name and Address of Facility 917 W. Bennie Smith Funeral Home Salisbu Isabella St. Salisbury, 23a. Part 1. Enter the disease, shock, or the rt failure. List only one in falions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Due to or as a consequence of: Exami ettending physician and i for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 month Pregnant at time of death Month Day signed by the et id be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hospital or Attending Physician: The law require 24 hours after death.
 Funeral Director: After this certificate has been sis in Funeral Directors. The funeral director, page 2 should etely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manns of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) arroll St. Salsbury, md State 27

DHMH 17 Rev 06-2011

Registrar

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		•	_ State Registrar				tificate of			Reg. No. 2	012	25941
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	Funeral Director		5. Social Security Number 222-34-1377  Usual Residence of Decedent		ge (In yrs. Ia 61	st birthday) Yrs.	If Under 1 Year Months Days			ay, Year)	Cour	place (State or Foreign htry) laware
	aryland la-f show	ector	10a. State 10b. County	sex		Town or Loc Seafo						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the M 23a or 28 ist be not	Funeral Director	10e. Street and Number 6784 Atlanta				10f. Zip Code	73		10g. Citizen of US	What Coul	
9036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1	12. Was Decedent Armed Forces' ed 1 1 Yes 2 1 If Yes, Give Year or Dates.	?		/as Decedent of Yes, specify Cub ☐ Yes ※/③XN		Specify Yes or No rto Rican, etc.)	1 510	ce - Americ ck, White, /: Whi	etc.
Baltimore, Maryland 21215-0036	thin 72 hou ene. than "natu he Medica	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) 1.2		5+)	(Give k	ent's Usual Occu ind of work done ONOT use retired	during most of w	orking	16b. Kind of E	Business/In	dustry
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Mary	d 2 should be file alth and Mental b 127 is marked of r traumatic ever		19a. Informant's Name/Relationshi Helen Moyniha	ip (Type, Print)	r				Rural Route Number			
more,	permit. Page 1 and 2. Department of Health Important: If item 27 any injury or other troops.	1000	20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation  4 ☐ Donation 5 ☐ Other (Sp	3 ☐ Removal from Stat	20h Pi	ace of Disposemetery, cremo	sition (Name of atory or other pla Cremat	ory 07,	Date /25/201	20c. Location 2 DOV	-City or To	
Balti	permit. 1 Departn Importa any inju		21. Signature of Juner J Service Li					i	ral Hom eaford,		 973	
Ç	Priysician/ Medical Examiner		23a. Part 1. Enter the disease, or a shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	ne. Septi s a conseque	. Do not ente						Approximate Interval Between Onset and Death
09	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as UTI  c. Due to (or as d								
). Box 68760	he death certificate be ex y the attending physician ached for use as the buria	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2  Fetal	death 3	Ectopic pregnar Other (specify)	псу			ate of deliver	ery Day Year
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Wheems.	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for	Completed							24a. Was auto perfe 1 \( \sum \) Yes	psy ormed2	Were autoprior to codeath?	psy findings available mpletion of cause of 2   No
$_{\chi}$	/sician: s certific director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 📉 No	Hospital:	tient 2 🗆 I	ER/Outpatient		Place of Death (Ch	eck only one)	14047		,
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# 2 J Division	l or Attend after death Director: /	Certificate:	2 ☐ Accident Investig: 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ot be 28e. Place of in	jury - At hor tc. <i>(Specify)</i>	ne, farm, stre	M 1 L	Yes 2 No	28f. Location ( City or Tox	Street and Numb vn, State)	er or Rural	Route Number,
· ·	ne Hospita n 24 hours ne Funeral pletely filled	Medical	(Check 2 L Medical Ex	Physician: To the best of caminer: On the basis of Nurse Prostitioner: To the basis of the basis	examination	and/or investi	gation, in my opin	ion, death occurred	d at the time, date a	and place and du	e to the car	use(s) and manner stated
	To the within comp		29b. Signature and title of certifier		M. 2		29c. Licens			29d. Date signe	d (Month, i	Day, Year)
	01C		30. Name and address of person w	ho completed cause of AH MET		23a) (Type, Pr				4B (SAL	usBu(	27 MD 21804
	Stat Registra	С .	31. Date filed (Month, Day, Year)	2012 32. sist	rar's Signatu	b. be	are					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death <sup>Day</sup> 2012 Physician/ Month Milsom Virginia 07:45 AM 4 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Ceci1 Caraway Manor Assisted Living E1kton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. JAN 9 Country) Delaware Director 1943 215-40-1528 Usual Residence of Decedent show I Hygiene. . other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 2375 Oldfield Point Road 21921 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🗓 No Specify: Specify: 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Rubber Products Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Machine Operator Manufacturing event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ည Frederick Owen Harvey Ruth Buckingham permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie K. Todd/Daughter 376 Catamount Road, Oxford, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cherry cremetery or other place) Methodist Cemetery 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 8, August 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 20I2 Cherry Hill, MD 21. Signat re of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton St., Elkton, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ ٦٩ع disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir nding physician and use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atten in the past 12 months?
1 Yes 2 No jo Pregnant at time of death Month Day Year signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform certificate 2 🗆 No Yes 1 Yes Hospital or Attending Physician: The hours after death. Funeral Director: After this certificate ted filled in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Hospital Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier V. Naye 08/06/2012 03065733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PULA ELKTON, MD A E-HG4 126 STreet 31. Date filed (Month, Day, Year, 32. Registrar's Signatu State 4 2012 Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 10am Month **Physician** /Medical 4b. City, Town, or Location of Death County of Death 4a Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Days Hours Months 1 M 2 □ F 21856878 Yrs. 0 Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Locetion r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No aro Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 2 Married 1 Never Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0020 Specify Specify: WHILE ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last, Mother's Name (First, Middle, Maiden Surname) State, Zip Code) 1 a. Informant's Name/R. lationship (Type, Print) Department of Health ar important: if item 27 Is any injury or other traughts. 19, MD211032 20b. Place of Disposition (Name of cemetery, prematory or other p Date 20c. Location - City or Jown, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Funera 311 S. Main St. Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 7 MONTHS PANCREATIC CANCER Examiner Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed TLYUS 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 🔲 Yes this eral Director: After the filled in by the funeral 28d. D scribe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 No death. 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Thomicide within 24 hours a To the Funeral L 29a. Certifier critifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 2012 DOO66489 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 8221 TEAL DRIVE, EASTON, MD 21601 DR. Q. WILLIAM GAI 31. Date filed (Month, Day, Yeer) 2. Registrar's Signature State 1 3 2012 Registrar

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**DHMH 16 Rev 6/95** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Year July 23, C. Nicholson 7:47 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Lorien Mt. Airy Mt. Airy 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 215-14-7512 1 **X** M 2 □ F 90 12/22/1921 MD Usual Residence of Decedent "natural", or items 23a or 28a-f shov idical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17383 Hardy Road 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married □**X**Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 3 X Widowed 4 Divorced Year or Dates. 42-46 Specify: White artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Operator Grocery/Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Reverdy Nicholson Irene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ron Nicholson (Son) 17383 Hardy Road Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, ChristChurch 7/26/2012 4 Donation 5 Other (Specify) West River, MD 21. Signature of Funeral Service Licensee Hardesty Funeral Home 22. Name and Address of Facility 12 Ridgely Ave Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween et and Death Immediate Cause (Final Physician/ chronic renal disease or condition Oyears Medical resulting in death) **Examiner** Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events use as the burial-transit and resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

A Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day 9 Unknown 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by woothy voidism 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 💢 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Primary Cone 29c. License number H58132 Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 24872 9815 Main Street Suite 248, Damascus Banjamin T. Tapoi, D.O. State Registrar

DHMH 17 Rev 06-2011

			1 - For State of N	Maryland / Dep Ce	oartment of F ertificate of I		_	giene Reg. No. 20	12 2594
	Dhuniai		Decedent's Name (First, Middle, Last)				2. Date of De		3. Time of Death
	Physici /Medi		Louis Napfel, J.				July	2-8 90	12 67/3 AM
	Examir	ner	4a. Facility Name (If not institution, give street and number	r)		Location of Death		4c. County of	Death
			Medstar Harby Hospital  5. Social Security Number 6. Sex 7.	Age (In yrs. last birthda	Balhmoi	If Under 24 Hrs.	MD 8 Date of Bir	th 9	. Birthplace (State or Foreign
	Funeral Director		213-26-6070 1⊠M 2□ F	81 Yrs.	Months Days	Hours Min.	Nov 9	th ay, Year) 1930	Maryland
	pr ,		Usual Residence of Decedent				1		-
	Aarylai f shov	or	10a. State 10b. County  Maryland Anne Arundel	10c. City, Town or I		dgewater			10d. Inside City Limits 1 ☐ Yes 2 🔯 No
	n the N	irect	10e. Street and Number		10f. Zip Code	24.027		10g. Citizen of Who	
	23a c	ra	409 Fairmount Drive			21037		U.S.	,A•
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Mudical Experiment must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Deceder Armed Force: 1 ☑ Yes 2 Ut Yes, Give Year or Dates	¬No l	3. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🗖 No		pecify Yes or No o Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
5-0	72 hor	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	cedent's Usual Occup	ation	kina	16b. Kind of Busin	ness/Industry
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Baltimore, Maryland	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Type. Print) Mary F. Napfel/wife		iling Address (Street armount				
ore	Pages 1 nent of H int: If iter		20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 □ Removal from Stat		position (Name of ematory or other place	e)	Date	20c. Location - Ci	•
ij	it. Pa irtmer irtant: njury		4 □ Donation 5 □ Other (Specify)		Mem. Gard 22. Name and Addres	1		Davidson	•
Ba	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee						Lis, MD 21401
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not e line.	enter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsis					Olissi uliu bauli
	Examiner		Due to (or a	as a consequence of):					
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	scuted nd rransit	Examiner	triat initiated events C.						
90,	cate be executed oblysician and the burial-transit		resulting in death) Last Due to (or a	as a consequence of):					
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Ä	The late has page	moC			<del>.</del>		autop perfo 1 □ Yes	rmed?   dea	or to completion of cause of ath? ]Yes 2 □No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:		low.	26. Place of Dea			
of	Phys rthis ral dii	<u>P</u>	1 ☐ Yes 2 ☐ No Pospital: 1 ☐ npa 27. Manner of Death 28a. Date of Ir			4 LI Nursing H		dence 6 Other	(Specify)
on	iding Ph th. : After thi : funeral	tion	1 Natural 5 Pending (Month, I	Day, Year) Injury	/ Work	Yes 2 □ No	zou. Describe	now injury occurred	
Division	I or Attendi after death. Director: A	Certification: To	3 Suicide 6 Could not be	njury - At home, farm, s etc. (Specify)	street, factory, office				or Rural Route Number,
	tal or rs afte al Dir led in	Cert	4 I Tomode Building,	sto. (Opecny)			City or To	wn, State)	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one)  1 ☑ Certifying Physician: To the besise and manner	of examination and/or	ath occurred at the tir investigation, in my o	me, date and place ppinion, death occu	e, and due to the rred at the time,	cause(s) and mani date and place, and	ner as stated. If due to the cause(s)
	To the within 2 To the сотрые	Me	29b. Signature and title of certifier		29c. License	e number		29d. Date signed (	Month, Day, Year)
	Tox		1 mm	MP	, ,	3001		July, 21	8,2012
	G. Ox		30. Name and address of person who completed cause of	death (Item 23a) (Type	e, Print)	11	Maraid	ral	
			Brandon Metcalt M 31. Date filed (Month, Day, Year) 32. Regis	strar's Signature	redstar	Har Doc	Horby	***	
	Sta Registr	_	JUL 31 2012	f death (Item 23a) (Type D strar's Signature	pare				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donald Eugene Odom 220/PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Easton 10/601 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) Director 220-66-5689 1 XM 2 □ F 55 7/24/1956 Maryland 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Caroline Maryland Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 Caroline Drive 21629 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 to Yes 2 No 1979

If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates. to 1981 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic event, the Megone. Elementary/Secondary (0-12) College (1-4 or 5+) Product Distribution Warehouseman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marvin Wheeler Odom, Sr. Dorothy Mae McCall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Odom, spouse 110 Caroline Dr., 21629 Denton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Capito1 7/17/2012 Dover, Delaware Crematory 21. Signature of Funeral Service Lice 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South 2nd Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ca la disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner セッナンと Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day 1 Yes 2 No page 2 should be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 Propatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number

Registrar
DHMH 17 Rev 06-2011

State

Washington St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis DeShields

16201

219 S.

JU1

21601

Easton, MD

12-05566 Leslie Olszack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 25947

		I- For State Registrar		Ce	ertifica	te of l	Death				R	eg. No.	Em 1	0 1 1	2 2394	
Physici		Decedent's Name (First, Middle,Last)  2. Date of Death  Month Day Year 1850 hrs														
Aedical Exami		LESLIE LOC	HRTICE	OT.SZAC	K						Month July 25, 2	Day 1012	Year		1850 hrs	
		4a. Facility Name (if not institution				4b	. City, Tow	n, or Lo	ocation of		, ==, =		ounty of	Death		
		26363 Burton Avenue	. •	,			Crisfield						nerse			
		Social Security Number	6, Sex	7. Age (In yrs.	last hirth	day)	If Under		If Under	24Hrs I	8. Date of Bi	rth(MM/DD	/////	9. Birth	place (State or	
Funeral						uay j	Months	Days	Hours	Min				Foreign		
Director		085-40-9133	1 M 2 XF	6	2	Yrs.					04/13,	1950		Cour	ntry) IL	
	ı	Usual Residence of Decedent														
, any	ſ	10a. State 10b. County		10c. Cit	ty, Town o	r Location	n			_				- 1	10d. Inside City Limits	
bi bew	اے	Maryland Son	nerset					Cr	risfi	leld					1 Yes 2 XNo	
Maryland <b>28a-f show</b> i at once.	윉	10e. Street and Number				Т	10f. Zip Co	ode			· T	I 0g. Citizer	of Wha	at Count	у?	
215-0036 be filed within 72 hours after death with the Maryland nutal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Director							218	217			USA				
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after after ner	à	3 Widowed 4 XDiv	orced If Yes, Give Ye	ear		11	∕es 2X	No	specify:			Sp	ecify:	1	White	
1215-0036 Id be filed within 72 hours afte fental Hygiene. narked other than "natural", event, the Medical Examiner		15. Decedent's Education (Spec		ade completed)			s Usual Oc					16b, Kin	d of Bus	iness/Ind	dustry	
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5-00 led wit Hygien other	듓	17. Father's Name (First, Middle,						18	.Mother's	Name (F	irst, Middle,	Maiden Su	rname)			
The all H	வ	Willard Fiske	Lochrid	ae TTT					Pa	atrio	cia Dav	ugher	ty			
0 E S	e o	19a. Informant's Name/Relations			19b.	Mailing	Address	Street a			ral Route Nu	_		, State, 2	Zip Code)	
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MD and 2 sho salth and 2 sem 27 is	ŀ	20a, Method of Disposition	-CIRVEZ (								Date				own, State	
sla fle frite			Burial 2 YCremation 3 Removal from State crematory or other place)											1	.,	
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Baltimore, permit. Pages 1 as Department of He Important: If ite injury or other tr	ŀ	21. Signature of Funeral/Service	Donation 5   Other Specify:   Signature of Funeral/Service Licensee										ਤ ਸਾ	INF:R	AT, HOME	
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هم درد		or condition resulting in death)		a consequence		n										
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Divisospital or A bours after meral Directly y filled in by	Certification:		rmined (Specify	1)						Į.	or Town,	State)				
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Divis  To the Hospital or A within 24 hours after. To the Funeral Direc	Medical	(Check only one) 2 ✓ Medical Exa	miner:On the basis	of examination	and/or in	vestigatio	on, in my o	pinion, o	death occ	curred at t	he time, date	and place	, and du	e to the	cause(s)	
To with Com	Nec	29b. Signature and title of certifie	and manner	stated.					number						h, Day, Year)	
	<b>~</b>	Jos. dignature and title of certifie	16 .1	<b>.</b> .				D.C.M				July 2				
		Yandelit With	rell, mi	)			`	J. U. IVI	. 4			July 2	.0, 20			
		30. Name and address of person														
		Pamela E. Southall, N	ID Assistant	t Medical Ex	kaminer	900	W. Balti	more	Street,	Baltim	ore, MD 2	21223				
s	tate	31. Date filed (Month, Day, Year)		Registrar's Sign	ature											
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DHMH 17 Rev 1/2	2004		JUL 3 0 2012 ORIGINAL ORIGINAL													

12-05846 n Alvin Officer

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

aron Alvin Offic		SIBIE 1- For State Registrar	e or Maryland /		artment of rtificate of		na ivien	tai Hygiene	Reg. No	20	12 2591
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle, La Alvin Aaron Offi						2. Date of D Month August	eath		3. Time of Death 0952 hrs
egical Exami	ilei	4a. Facility Name (if not institution, g				4b. City, Town, o	or Location of			c. County of Dea	
		Shady Grove Hospital  5. Social Security Number 6. 6.	7.000	/1= I	and birdhada. N	Gaithersbu		25 241 les 10 Date of		Montgomery	irthplace (State or
Funeral Director		513–78–7125	Sex 7. Age	35	ast birthday) Yrs	Months Da			4/19	Foro	
any.		Usual Residence of Decedent  10a, State 10b. County	I		Town or Locat						10d. Inside City Limits
Aaryland 28a-f shuw 1 at once.	ē	MD Montgon	ery	Gait	thersbu				1		1 Yes 2XX No
death with the Maryland or items 23s nr 28s-f shn must be notified at once.	I Director	10e. Street and Number  106 Billingsgate	Ln.			10f. Zip Code 20877			US	tizen of What Co	untry?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a nr 28a-f shumaic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 X Divorce	12. Was Decedent E Armed Forces? 1 Yes 2	Ever in U. No			an, Mexican	gin? ( Specify Yes or , Puerto Rican, etc.)	No-	White, etc.	rican Indian, Black, Lack
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5-0036 led within 72 hours at Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or 5- 5+	+)		ation Sp	pecial	list	Te	chnology	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Las Alvin D. Officer						's Name (First, Middl ena C. Whi		n Surname)	
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Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Impurtant: If item 27 is marked other the injury or other traumante event, the Med		20a. Method of Disposition  1 Burial 2 X Cremation 3  4 Donation 5 Other Specie		ا ا	crematory or other	sition (Name of c herplace) 1 Crema		Date 08/10/201		Location - City o	·
Baltir permit. I Departme Impurta		21. Signature of Europe at Service Lice		MO	1452 Ba	Name and Address iley Fui 23 Annai	ss of Facility neral	Home and Rd., Hale	Crem thor	ation Se	ervice, PA 21227
Physician		23a. Part I. Enter the disease, or con failure. List only one cause on o	nplications that caused to each line. Queti;	he death.	Do not enter to	he mode of dying ication	g, such as comp	ardiac or respiratory Licating 1	arrest, sh	ock, or heart tensive	Approximate Interval Between Onset and
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60, ate be exe ohysician	Medi	IF FEMALE:	11-9-12 SN 23c. If yes, outcome	1		, F , -			1,000	d. Date of delive	ry
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O. B. at the de lby the tached f	Phy	Part II. Other significant conditions		but not re	esulting in the u	underlying cause	given in Pa	art I. 23e. Di	d tobacco	use contribute to	the cause of death?
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ttendin death. ctor: A	ation	1 Natural 5 Pending 2 Accident Investiga	fd 8-5-	-12	fd 09:0	и ащ	Yes 2 🗶				
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Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director:	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 W Medical Examin	cian: To the best of my er: On the basis of exam and manner stated.	knowledo ination a	ge, death occur nd/or investigat	rred at the time, o	date and pla on, death oc	ace, and due to the co	ause(s) ar ate and pl	nd manner as sta ace, and due to t	ited. he cause(s)
E 3 E 3	Me	29b. Signature and title of certifier	and marrier stated.				nse number			Date signed (Me	onth, Day, Year)
		30, Name and address of person who	completed cause of de	J A	14 2 23a)	),   0.0	.M.E.	OCME	Aug	gust 8, 2012	
		Thendore M. King, Jr., M	D. Assistant Me	edical E	xaminer	900 W. Balti	more Str	eet, Baltimpre,	MD 212	223	
St Regis	ate trar	31. Date filed (Month, Day, Year)  AIG 1 4 2012	32. Registrar	- ,	ire a design						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0557 AM Rudolph Patrick 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Elkton, MD Cecil Union Hospital Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Sex 1X M 2 □ F Age (In yrs. last birthday) 8. Date of Birth Days (Month, Day, Year) 8 - 23 - 1930 Hours 81 Director 236-38-7646 WV Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 282-4-100. Once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Harrington Kent DE1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19952 USA Funeral 311 Harrington Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by White 1 ☐ Yes 2X No Specify: Specify 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Truck Driver 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Etta Williams Roy Patrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Wardson Dr., North East, MD 21901 Fay Foster/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Summit Cremation 7/28/2012
Services, LLC 1 Burial 2 Cremation 3 Removal from State Wyoming, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pippin Funeral Home, 119 W. Cam-Wyo Ave., Wyoming, DE 19934 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 29a. Part 1. Enter the disease or shock, or heart failure. List only Onset and Death Immediate Cause (Final ISCHEMIC CARDIOMYOPATHY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CNCEPHALOPATHY ANOXIC Esquertially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed. Yes 2 death? 2 🗌 No To the Hospings within 24 hours after death.

To the Funeral Director. After this certified to the Funeral director, at all all in by the funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 

✓ Inpatient 2 

ER/Outpatient 3 

DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer D63466 JULY, 26, 2012 MD

Registrar

O DHMH 17 Rev 7/2009

106 BOW

32. Registrar's Signature

STREET, ELKTON, MD 21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAMADEH

NATHAN
31. Date filed (Month, Da

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FOUNDAME PARTY Physician/ 1620 ONTON Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Bostimore Maryland Midical Center University Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Min. Hours Director 214-46-5817 1**X** M 2 □ F (O (O 2/15/46 Maryland er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 USA 911 Shawnee Drive 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces? 12 Yes 2 No 1964-Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 1968 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) +2 District Court Commissioner Government 2 should be filed with h and Mental Hygien 7 is marked other th other traumatic event, Be 17. Father's Name (First, Middle, Last)

John L. Parton 18. Mother's Name (First, Middle, Maiden Surname) 2 Helen Fogle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Shawnee Dr., Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 sh nt of Health a Elizabeth Ponton / Wife Department of He. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State emetery, crematory or other place) 7/30/2012 Frederick, Maryland Resthaven Donation 5 Other (Specify) Stauffer Funeral Home 21. Signature of Futieral Service Licensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter (the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury and I-transit ymphoma that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician ar Physician/Medical Box 68760 attending pl d for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the s Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 X No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Natural 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 0001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225. Gircenc 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ı	For State Registrar	State of Ma	-	artment of He tificate of De	ealth and Ment eath	tai Hygiei Reg.	2013	25951
	Physicia		Decedent's Name (First, Middle, Last)     Mona	Jean	Pa	rsons		ate of Death	2012 Year	3. Time of Death 2:30 PMM
	Medio Examir		4a. Facility Name (if not institution, give s			4b. City, Town, or Lo			4c. County of Death	<del></del>
- Spanner (	Funeral		6400 86th. Ave. 5. Social Security Number 6. Sex	7. Age (	(In yrs. last birthday)		Carrollton  If Under 24 Hrs. 8, D	ate of Birth	Prince G	eorges
	Director		235-52-8357	м 2 <b>X</b> F 79	Vre		Hours Min. (A)	fonth, Day, Yea	933 Wes	st Virginia
	and show dat	ğ	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary 28a-f	)irec	Maryland Prince G	orges	New Car	rollton				1 🏹 Yes 2 □ No
	with the 23a or st be	Funeral Director	10e. Street and Number 6400 86th Avenue	2		10f. Zip Code		10g.	. Citizen of What Cou	ntry?
	items			Was Decedent Eve Armed Forces?		20784 Vas Decedent of Hisp	anic Origin? (Specify Ye Mexican, Puerto Rican,	es or No-	14. Race - Ameri	
036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene.  Marked other than "natural", or items 23a or 28a-f show marke other than "natural", and items 23a or 28a-f show matic event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married  3X☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.	0	Yes 2 No		010.)	Black, White, Specify:	
2-0	"natur edical	Completed	15. Decedent's Edu (Specify only highest grad	cation	(Give I	lent's Usual Occupation	on ing most of working	16b	o. Kind of Business In	ite ndustry
Maryland 21215-0036	within 7 giene.		Elementary/Seconday (0-12)	College (1-4 or 5+)	Homen	O NOT use retired)			Own Home	
nd	filed tall Hyg	To Be	17. Father's Name (First, Middle, Last)		T IICATE I	1.	8. Mother's Name (First		len Surname)	
ıryla	2 should be Ith and Ment 27 is marked traumatic e	-	John G. Peacock  19a. Informant's Name/Relationship (Typ)	Print)	10h Mailin		Ruth Shiff]  Number or Rural Rout		Chat Taura Chata 7:-	0-4-1
	ge 1 and 2 should be it of Health and Men I fitem 27 is marke or other traumatic		James Parsons, Jr		16 V	Ridge Rd	. Greenbelt	MD 2	0770	
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If Item 2 any injury or other 3 once.		20a. Method of Disposition  1 🖸 Burial 2 🗶 Cremation 3 🗆 F	emoval from State	20b. Place of Dispo cemetery, cren	natory or other place)	Date 07/20/2	T I	Location - City or T	
altir	permit. Pa Departme Importan any injury once.	1	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Full eral Service Licenses	1			ry 07/30/2			
m	e a E e e	- 1	Muham	Done			olis Rd. La		MD 20706	
	h sician		23a. Part : Enter the disease or compli shock, or heart failure. List only one Immediate Cause (Final	ations that caused the cause on each line.	ne death. Do not ente	r the mode of dying, s	such as cardiac or respi	iratory arrest,		Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as a c	sequence of):	y 0/+10	ese		-	icyan
	Examiner	er	Sequentially list conditions,	Hyper Du Forasa d	Heus con					10 years
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Dials	Les 14	ne II				1 Viller
	certificate be executed and physician and use as the burial-transit	alEx	resulting in death) Last	Due to (or as a c	consequence of					7
3760	ficate b g physi as the b	<b>Medical</b>	d							
89 X	th certii ttending or use a	Physician/M	Zob. Was decedent pregnant	c. If yes, outcome of 1 Live Birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of deliv	
Box	he dea y the a iched fe	hysic	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown	me of death 5 L	Other (specify)			Month	Day Year
О.	s that t gned b be deta	by	Part II. Other significant conditions con	ributing to death but	not resulting in the u	nderlying cause given	in Part I.		o use contribute to t	**
rds	require been si should	eted								bably 4 🖾 Unknown
ě	he law tte has	Completed						4a. Was an autopsy performed:  ☐ Yes 2 X	prior to co death?	psy findings available mpletion of cause of
<u> </u>	cran: I	Be	25. Was case referred to medical examiner?	spital:			of Death (Check only c		NOT TELL TES	2 🗆 NO
Z .	Physical this care directly and the care dir	e: To	1 ☐ Yes 2 No Ho  27. Manner of Death	1 ☐ Inpatient 28a. Date of injury	28b. Time of	DOA Other:	4 Nursing Home 5	Residence		2
on	ending eath. or: Afte he fund	Certificate:	Matural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Y	<i>(ear)</i> injury	work?	s 2 🗆 No	escribe now my	jury occurred	
Division of Vital Records, P.	Io the hospital or Attending Physician: The law requires that the death certific within 24 hours after clear.  To the Funeral Director: After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (\$	- At home, farm, stre Specify)	et, factory, office		ocation (Street a ty or Town, Sta	and Number or Rura ate)	Route Number,
<u> </u>	lospita † hours uneral ed fillec	edical	29a. Certifier Check 2 Medical Examine	an: To the best of my	/ knowledge, death o	ccured at the time, da	ate and place, and due to	to the cause(s)	and manner as state	ed. use(s) and manner stated.
	o the Prithin 24 or the From plet	Σ	only one) 3 Certifying Nurse  29b. Signature and title of certifier	Practioner: To the bes	st of my knowledge, d	eath occurred at the tin	me, date and place, and	due to the caus	se(s) and due to the ca se(s) and manner as st Date signed <i>(Month</i> ,	ated.
			1 ~				1722		7-30-2	
	10 Tm		Name and address of person who con		, ,,,,,	,	#2 P7 - 7	,		1073.0
	Stat	•	Vicken K. Poochik 31. Date filed Month, Day, Year)	32 Registrar's	Signature		#3 Bladens	ourg, N	varyland 2	:U/T0
	Registra	r	JUL & AZUT	Dems	p. pa	KI				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>Day</sup> 2012 JulyTommaso Pasquini 30 9:25 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Upper Marlboro 200 King James Road Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Ye Director 578-58-8903 XX M 2 D F Nov. 4, 1925 Italy 86 ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Upper Marlboro 1 X Yes 2 □ No Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 USA 200 King James Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 X Married Yes 2 X No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", edical Exar Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Barber Barber Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည of Health and Menta fitem 27 is marked rother traumatic ev Carmella Mariggi Nicoangelo Pasquini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 King James Road, Upper Marlboro, MD 20774 Fiorenza Pasquini - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State Lakemont Mem. Grdns 8-2-2012 Davidsonville, MD 4 Donation 5 Other (Specify) 21. Signature of Juneral Sen 22. Name and Address of Facility Beall Funeral Home <u>6512 NW Crain Hwy. Bowie. Maryland 20715</u> 23a. Part 1. Enter the disease, or control cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Parkinson's disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months? Dav Year 1 Yes 2 No After this certificate has been signed by the a funeral director, page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 M No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDDA 4 Nursing Home 5 Nesidence 6 Other (Specify, 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 5 Pending 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cruter Drive #201 Bowe, Maryland 2071,6 Kelvin Hao 14999 MD Health State

DHMH 17 Rev 06-2011

Registrar

			1 - State Registrar	oldio of Mary		tificate of l			Reg. No.		
	Physicia Medi		1. Decedent's Name (First, Middle Arlene	Tom	Peter	s		2. Date of De		1Ž <sup>ear</sup>	3. Time of Death 9:23 A M
	Examir	ner	4a. Facility Name (if not institution 3007 Tinker				r Location of Deat Shington	h		y of Death Ce Ge	orge's
	Funeral Director		5. Social Security Number 216-04-3107 Usual Residence of Decedent	6. Sex 7. Age (In 1	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da 05/07	th y, Yea <i>r</i> ) /1973	Coun	olace (State or Foreign try) th Carolina
	Maryland 28a-f show xtified at	rector	10a. State 10b. County	ce George's	C. City, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2XXNo
	with the s 23a or 2 ust be no	Funeral Director	10e. Street and Number 3007 Tinker	Drive	-	10f. Zip Code	20744		10g. Citizen of		utry? USA
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 <b>X.X</b> Divorced	If Voc Civo	l'	Was Decedent of H f Yes, specify Cuba	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - Americ ck, White, e	
Baltimore, Maryland 21215-0036	vithin 72 ho iene. ir than "nat the Medica	Completed		ent's Education lest grade completed)  College (1-4 or 5+)	I (Give I	lent's Usual Occup kind of work done o O NOT use retired) ation Cle	during most of war	king	16b. Kind of B		Congress
/land :	d be filed v Viental Hyg arked othe	To Be	17. Father's Name (First, Middle, Willie Washi	Last) ington Peters				me (First, Middle, a Louise		e)	
, Mar	nd 2 shoul ealth and i n 27 is m er trauma	3	19a. Informant's Name/Relations Barbara L. Pet		I	g Address (Street a				State, Zip C	Code)
ımore	permit. Page 1 ar Department of He Important: If iter any injury or oth		20a. Method of Disposition 1 ☐ Buria 2 Cremation 4 ☐ Donation 5 ☐ Other (-	3 Removal from State	Pob. Place of Disposic Cemetery, crem Kalas Cr	ematory or other place	! // 5	Date 0/2012	_	ater,	Maryland
Rail	permit Depart Impor any in		21. Sign dure of Funeral Servi	Light see	6	. Name and Addres	ss of FacilityGeo Hill Rd.	orge P. Oxon H	Kalas Fu ill, Man	ıneral ryland	l Home PA 1 20745
1	Physician Medical	W 1	23a. Fart 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each line.  Breast Ca	ancer	r the mode of dyin	g, such as cardiac	or respiratory an	rest,	у	Approximate Interval Between Onset and Death <b>EATS</b>
	Examiner	<u>.</u>	Sequentially list conditions,	Due to (or as a cor	nsequence of):						
	ificate be executed go physician and as the burial-transit	al Examiner	hany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor	, , ,		-				
2/00	ficate be g physic as the bi	Medical		d		-					
. Box oc	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 PNo 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnance Other (specify)	у			te of delive	ry Day Year
us, r.o.	quires that the signed by auld be deta	by	Part II. Other significant condition	ons contributing to death but no	ot resulting in the ur	nderlying cause giv	ren in Part I.				e cause of death?
Records,	The law rec cate has been page 2 sho	Completed						24a. Was a autop perfo	rmed?	Were autop prior to con death? 1 \( \subseteq \text{Yes} \)	ssy findings available inpletion of cause of
N Ed	sician: certific rector	Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☒ No	Hospital:		Othe	ace of Death (Chec	ck only one)			
2	g Physer this eral di	e: 10	27. Manner of Death	28a. Date of injury	2 ER/Outpatient 28b. Time of	28c. Injury	4 L Nursing H	ome 5XX Resid	ence 6 Othe		
	ending sath. vr: Afte he fun	ficat	1 XXNatural 5 ☐ Pendir 2 ☐ Accident Investi	gation	ar) injury	work					
DIVISION	vital or Atte urs after de ral Directo illed in by t	al Certificate:	3 Suicide 6 Could 4 Homicide determ	nined 28e. Place of Injury - A building, etc. (Sp	pecify)			City or Tow			·
	the Hosp hin 24 ho the Fune πpletely f	Medical	only one) 3 Certifying	g Physician: To the best of my k Examiner: On the basis of examin g Nurse Practitioner: To the bes	nation and/or investi	gation, in my opinio	n, death occurred a	at the time, date a	nd place, and due	e to the cau	se(s) and manner stated.
			29b. Signature and title of certifier	2200	~	29c. License			29d. Date signed		
?	430			es, M.D. 3720 U	pton St.		shington	, DC 200	016		
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	0. 4.1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2012 Physician/ Joanna J. Price aM July Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 531 Randolph Road, Apt. A322 Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Year) Country 230-24-6140 Director 1 🗆 M 2 🔀 F Yrs March 19, 1926 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 Ves 2 1 No MD Silver Spring 10f. Zip Code Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 531 Randolph Road, Apt. A322 20904 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify Completed 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) Executive Secretary US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Smith King Nannie King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Jefferys/Daughter 14125 Porringer Court, Burtonsville, MD 20866 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State Injury or July 30, 4 Donation 5 Other (Specify) Parklawn Memorial Park Rockville, MD 21. Signature of Juneral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ a Acute Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial transi The law requires that the death certificate be executed Hypertension Due to (or as a consequence of): Physician/Medical Diabetes Mellitus- Type II Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month been signed by the a should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Seizure Disorder, Carotid Stenosis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it completely filled in by the funeral director, page 1 Yes 2 No Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Centifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title q dertifie 29c. License number D53691 July 26, 2012 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) 3200 Tower Oaks Blvd. #110, Rockville, MD 20850 Ajay Reddy,

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible,

1:00 PMM

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate nterval Between 19 Years

1 Yes 2 XNo

Marvland

14. Race - American Indian,

Black. White, etc.

Specify: White

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No

Year

Month

August 3, 2012

Records,

To the Hospital or Attending Physician: The law requires M

State Registrar

Martha J. Pierce, M.D., 300 West Ninth Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ranth

D 46248

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25956 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27 Day Physician/ JULY 2012<sup>ear</sup> 2:50 P M BRENDA CAROL REID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death DORCHESTER CHESAPEAKE WOODS CAMBRIDGE If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** OCI. Pay, 1 □ M 2 🗓 F Min. Months Days Hours Year) 956 MARYLAND 216-64-7691 **Director** 55 Usual Residence of Decedent e filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND DORCHESTER EAST NEW MARKET 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3902 LEE COURT 21631 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other them. QUALITY CONTROL INSPECTOR MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JAMES CARLTON NEWCOMB, SR. MARY ROSE MILLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOE L. REID/HUSBAND 3902 LEE COURT, EAST NEW MARKET MD 21631 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State DORCHESTER MEM. PARK 8/1/2012 4 Donation CAMBRIDGE MD 5 Other (Specify) f Juneral Service Live ZZELLER FUNERAL HOME, P. O. BOX 207 106 MAIN STREET, EAST NEW MARKET MD Interval Between Onset and Death shock, or heart failure. List only one ca Immediate Cause (Final Physlician/ Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Pregnant at time of death Year 1 Yes 2 9 Unknown signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 performed? 2 🗌 No Yes 2 LA 1 Tes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 400 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse real-tioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

**Division of Vital** 

BYRN

503

ST CAMERIDAE MD 216/3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TITANEN

VOMBON

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Elizabeth A. Reidy 2012 25 8:22 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Rehab. and Nursing Ctr. Sandy Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 578-05-4475 (Month, Day, Year) Director 1 □ M 2 🖾 F 96 Yrs. Dec. 6, 1915 Washington, DC 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
If the 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits Directo Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2417 Kaywood Lane 20905 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 Midowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) J6b. Kind of Business/Industry Johns Hopkins (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Applied Physics Lab Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Percy D. Roach May Belle Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon R. McCombe/Daughter 2417 Kaywood Lane, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any Injury or ot
once. Date 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) July | Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 2012 Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spri 21. Signature of Funeral Service Licensee Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ a. Pneumonia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bladder Cancer, Breast Cancer, COPD, Renal Stone, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 X No 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certifical etely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 K Nursing Home 5 Residence 6 Other (Specify) Hospital: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical To the Hosp within 24 hou To the Funer completely fil 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d Date sinned (Month, Day.) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D57630 July 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Anuradha Arun, MD 10301 Georgia Av

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

30

32. Registrar's Signature

10301 Georgia Avenue, #209, Silver Spring, MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ellen Irene Schwendener August 2012 12:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Envoy of Denton Denton Caroline Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Min. Director 219-05-6402 1 🗆 M 2 💢 F 89 6 1922 Delaware "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 420 Colonial Drive USA 21629 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene, marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) ll-grad <u>line worker</u> food industry Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filec trent of Health and Mental H-tant: If item 27 is marked ot jury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) <u>.</u>0 Harry Griffith Lovie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Griffith/ 26953 Beck Road; Federalsburg, Maryland 21632 nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, permit, Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery Aug 3 2012 Greensboro, Maryland 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 21. Signature of uneral Service Lice e Fleegle and Helfenbein Funeral Home, 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the huria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autonsv Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မှ 4 Kursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death s after death. Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? → Natural 5 Pending iniury 2 🗌 No Accident Investigation Suicide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours a Medical 29a. Certifier 14 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Pay, Year) 0047534

DHMH 17 Rev 06-2011

State

Registrar

street.

. Registrar's Signature

Denton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Market

920

AUG # 1 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Yea Irene Edna Sculley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Easton Talbot If Under 1 Year | If Under 24 Hrs. . Social Security Number **Funeral** 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Hours Director 220-28-4708 1 🗆 M 2 🛛 F 81 12/24/1930 Marvland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Caroline 1 X Yes 2 No Maryland Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21660 USA 206 Sunrise Ave. 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11 H.S. Grad. College (1-4 or 5+) Family Homemaker Be permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked oth any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick Rampmeyer Lucy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Sculley, Sr./spouse 206 Sunrise Ave. Ridgely, Maryland 21660 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ridgely Cemetery 8/2/2012 Ridgely, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South 2nd Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 NO 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, ဥ 1 🗌 Yes 2 1 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. Washington St., Easton, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

BU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Rose Schrecengost 2220 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Easton TAlbot If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 178-26-6989 Director 1 □ M 2K) F 79 6, 1932 Oct. Pennsylvania r than "natural", or items 23a or 28a-f shov the Medical Extending must be notified at 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 X No Caroline Goldsboro 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 14914 Day Road 21636 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 ☐ Divorced Specify: White chrecengost Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Ite Ma Elementary/Secondary (0-12) College (1-4 or 5+ Clerk State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Domenico Zaffora Teresa Puliphroni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Gavin 14914 Day Road Goldsboro, MD 21636 daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 7-26-12 Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home P.O. Bx 160 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Metastatic Cancer with Unknown Sequentially list conditions, Due to for as a consequence oil. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and burlal-transit Examil To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Stenosis ritical Apostic Due to (or as a consequence of): resulting in death) Last Physician/Medical cx to penia Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) g 🗌 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Mohan DOD 69 5 67 July ,23,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Mohan 219 S. Washington St. Easton Md. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 19 2012 1:00 Linda Mae Shanks Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Caroline Caroline Preston 20948 Tanyard Estates Drive Social Security Numbe If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕮 F Days Months Hours 4/107 1951 <sup>c</sup>Pennsylvania **Director** 61 170-44-7114 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Maryland Caroline Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20948 Tanyard Estates Drive 21655 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify. Completed 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 H.S. Grad. College (1-4 or 5+) Mail Service Customer Service Representative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Shirley Mae Emig Robert Edward Crowl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20948 Tanyard Estates Drive Preston, MD 21655 Wayne Douglas Shanks/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dover, Delaware Capitol Crematory 7/20/2012 Signature of Funeral Service Licer 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South 2nd Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Conset and Death Phytician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of s after death. Certificate: 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year, Natural 2 Accident 5 Pending injury Investigation M 1 Yes 2 No 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

509 Idlewild Ave

sistrar's Signatur

Easton, MD

21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary DeShields

31. Date filed (Month, Day, Year)

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11	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Nur 6145 Be	mber ethlehen	n Road		- "	10f. Zip		165	5		10g. (	Citizen of V Jnit	What Coun	tates	
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11	ospita hours uneral	Medical	29a. Certifier 1 (Check 2	Certifying Phy	ysician: To the best of r	ny knowle	dge, death o	occurred at	the time	e, date an	d place, ar	d due to the o	cause(s)	and manr	er as state	d.	
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			Journal of John Botsis, 249 S. Washington St. Easton, Md. 2160														
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DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 28. Alma L. Stone AKA Alma S. Stone July 2012 12:45  $\mathbf{A}^{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Glade Valley Nusing & Rehabilitation Center Walkersville Frederick 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days (Month, Day, Year) 214-14-6987 93 Director 1 🗌 M 2 🔀 F November 4, 1918 Maryland ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> Oa. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 336 Catoctin Avenue 21701 United States of America 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify than "natural", White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic source in the companies of the compan Lab Worker Federal Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lester C. Stockslager Ida Mae Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Moler / Daughter 2709 Wolfe Drive, Knoxville, Maryland 21758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 

■ Burial 2 

Cremation 3 

Removal from State August 1. Mount Olivet Cemetery Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Dipens 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy perform death? 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2. No 1 🗌 Yes Other: မူ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Funeral Director: A completely filled in by the 1 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signatu and title son who completed cause of death (Item 23a) (Type, Print) REDERICK 2 1704 GILSON GUI

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death <sup>Day</sup> 2012 July Physician/ Lillian Schweitzer 4:00 P. M 25 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Edenton Retirement Community Frederick Frederick Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 579-09-2543 Director 1 □ M 2**X** F 99 May 26, 1913 New York Usual Residence of Deceden items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director KY Warren Bowling Green 1X Yes 2 □ No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 1502 Scottsville Road 42104 United States death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify: White 3X Widowed 4 □ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 72 tr of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Scheller Lillian May Scheller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fovao Atalla/Grandson 1502 Scottsville Road, Bowling Green, KY 42104 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of July 25 2012 20c. Location - City or Town, State Georgetown University Medical Center 1 Burial 2 Cremation 3 Removal from State injury or Department of Important: If any injury or 4 ☑ Donation 5 ☐ Other (Specify) Washington, D.C. ona re of Funeral Service 22. Name and Address of Facilit Columbia Mortuary Services, P.A. /M00969 9013 Annapolis road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Dementic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Examine Due to (or as a nonsequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Por in the past 12 mo Month Dav Year Pregnant at time of death signed by the at d be detached fo Yes 2 No 1 | Yes 2 P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an has perform I or Attending Physician: The after death.

Director: After this certificate by 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Sec UV Other: 2No 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled To the Hospital Medical 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number 7-30-2012 D60417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Hemen Shah Dr. Frederick MD Dhnson Thomas 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 30 JUL 2012

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Towns.	-	- 6	Sir-rate	91.00	145	200	-	

			1- For State Certification Certification	ate of Death	Reg. No		
P ledical	hysici: Exami	an/	Decedent's Name (First, Middle, Last)     Shelton Lee Schroth		2. Date of Death Month Day July 28, 2012	Year 3. Time of Death 0940 hrs	
			4a. Facility Name (if not institution, give street and number) 6703 Atwood Street Apartment 5	4b. City, Town, or Location of Death District Heights	4	c. County of Death Prince George's	
	ineral rector		5. Social Security Number 6. Sex 7. Age (In yrs. last birt 219–96–6815 1 M 2 F 35	thday) If Under 1 Year If Under 24Hrs  Months Days Hours Min.  Yrs.	_	MDD/YYYY) 9. Birthplace (State or Foreign Country) MD	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If them 27 is marked other than "natural", or items 23a or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town MD Prince George's Bowie	or Location		10d. Inside City Limits	
e Maryland			10e. Street and Number 12322 Millstream Drive	10f. Zip Code 20715	10g. Ci	tizen of What Country?	
seath with th			11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 X No	Was Decedent of Hispanic Origin? ( Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.	
nours after o			3 Widowed 4 N Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a.	1 Yes 2 No specify:  Decedent's Usual Dccupation (Give kind of viduring most of working life. DO NOT use reti		Specify: White Kind of Business/Industry	
<b>21215-0036</b> Juld be filed within 72 l			Elementary/Secondary (0-12) College (1-4 or 5+)  8  17. Father's Name (First, Middle, Last)	uto Body Painter	e (First, Middle, Maide	Automobile	
215- be filed			Phillip R. Schroth	Kathy Lou	Berry		
MD 21 nd 2 should			Phillip R. Schroth / Father 90	b. Mailing Address (Street and Number or F 08 Copley Avenue, Waldorf	, MD 20602		
imore, Pages 1 and			1 Burial 2 Cremation 3 Removal from State Riverda 4 Donation 5 Other Specify:	of Disposition (Name of cemetery, tory or other place) ale Park Crematory  22. Name and Address of Facility	ust 3, 2012	Riverdale Park, MD	
Ball permit	Depart Impor injury		21. Signature of Eurheral Service Licensee	7 4111 Pennsylvania Ave	nue, Suitl <i>a</i> nd	1, MD 20746	
Phys	sician edical miner		23a. Part I. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Intended to dying, such as cardiac or respiratory arrest, shock, or heart Between Onset are Death  Death				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated (Disease or injury that initiated)						
uted	Attending Physician: The law requires that the death certificate be executed reath.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	Exa	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.				
<b>60,</b> ate be exec		Medical		a-f,per me,g930 8-16-			
Box 6876 e death certificate		Physician/M	past 12 months?	2 Fetal death 3 Ectopic pregna		3d. Date of delivery Month Day Year	
P.O. Bos that the de		à	Part II. Other significant conditions contributing to death but not resulting	ig in the underlying cause given in Part I.		o use contribute to the cause of death?  No 3 Probably 4 V Unknown	
Division of Vital Records,		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  No 1  Yes 2 No	
Lean S. T. San S. T. San S. T. San S. T. San S. Sa	his certificate director, page	Be	25. Was case referred to medical 26. Place of Death (Check only one)				
of Vid	the Hospital or hin 24 hours afte the Funeral Dir upletely filled in	ဦ	1 ✓ Yes 2 No 1 Inpatient 2 ER/0  27. Manner of Death 28a. Date of Injury 28b.	Outpatient 3 DOA Other Nursin	ng Home 5 Residence Reside	dence 6 🗹 Other Scene	
ion (		ation	Z Accident Investigation -	d 9:30 am 1 Yes 2 X No	unknown		
Divis		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, for determined (Specify) Fd:Resider	arm, street, factory, office building, etc.	28f. Location (Street or Town, State) District Ho	and Number or Rural Route Number, City 6703 Atwood St. Apt 5 eights, MD.	
To the Hos		Medical (	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	> 10	ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		I. Date signed (Month, Day, Year)  Iy 29, 2012	
	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 900 W. Baltimpre Street, Baltimpre, MD 21223						
	S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	bark			

amend item per do bepartment of Health and Mental Hygiente For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wendell Dean Sears Jr. 25<sup>ay</sup> 2012<sup>au</sup> Sr. July 5:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Household of Angels Severna Park Anne Arundel **Funeral** Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours (Month, Day, Year) Director 220-05-3406 1 **X** M 2 □ F 90 Yrs 12/25/1921 MD Usual Residence of Decede or 28a-f shov 10b. County within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Annapolis 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 519 Harbor Drive 21403 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married by Maryland 21215-0036 1 Yes 2 No Specify. 3 X Widowed 4 Divorced WWII Specify: White Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Manager Food Industry Be permit. Page 1 and 2 should be filed be partment of Health and Mental Hyg Important: If item 27 is marked othany injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Annie Virginia Klinefelter Fritz Lee Sears Fitzhugh Lee Sears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Basil (daughter) 519 Harbor Dr. Annapolis, MD 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran Cem 7/30/2012 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 31y. Hardesty Funeral Home 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PNEUMONIA Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner OBSTRUCTIVE LUNG DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed DEMENTIA Due to (or as a consequence of physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Day Year signed by the at d be detached for Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHAONIC RENAL INSUFFICIENCY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown PRESTATE HYPERTROPHY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No death? 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after death. 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title.of 2 127157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RMYNOLD DEPESTRE 3100 LOAD BALTIMORE DRIVE, BALTIMORE MD 21244 State JUL 31 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 20 rear 6:04p M ari Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Easton Talbot 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 216-80-447 Director 1 M 2 - F 64 =lorida or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location injury or other traumetic event, the Medical Examiner must be notified at 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marv. Deperment of Health and Mental Hygiene. Important if item 27 is merked other then "norther traumeting any night or other traumeting." 1 Ves 2 □ No Talbo Michaels 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Yes 2 No Black, White, etc. \$ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) estauran Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ဂ္ Stocker 19a. Informant's Name/Relationship (Type, Print) 30101 uincu 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place COM. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee cility Henry MD, 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final septicemia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Index) Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires thet the death certificate be executed detached for use as the burial-transit Cause (Disease or injury that initiated events After this certificate has been signed by the attending physician and formeral director, page 2 should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alcoholism 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 1 Inpatient 2 KER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 1 🗌 Yes 2 🗆 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Projection:

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) mad 219 S. Washington Street, Easton, MD 21601 State AUG 08 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 29 Day Physician/ JULY 2012 ear 2056 WILLIAM M. SHENK Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Min (Month, Day, Year) Country) 200-46-0725 **Director** 1 XM 2 □ F JAN. 2,1961 PENNSYLVANIA Usual Residence of Decedent items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🏻 No PΑ CHESTER DOWNINGTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 48 MAY APPLE DRIVE 19335 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes þ 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify WHITE Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. is marked other tha ACCOUNTING ACCOUNTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ELIZABETH L. BRAUNGARD WILLIAM A. SHENK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains ELIZABETH L. SHENK/MOTHER 268 BENDER ROAD, MILLERSVILLE, PA 17551 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 X Cremation 3 X Removal from State LEOLA, PA EVANS CREMATION SERVICE: 8-1-2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Si at ve of uneral Service ZELLER FUNERAL HOME, P. O. BOX 207 EAST NEW MARKET MD 21631 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the disease, or shock, or heart failure. List o Approximate Interval Between Onset and Death Immediate Cause (Final Ph, ician/ Intra crania Hemmerhage (non + roumati disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pitwitory Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or): 8 Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Diabetes. 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 25 Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? 1 X Yes 2 ☐ No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 200 1 X Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Number Practitioner to the best of my knowledge death occurred at the time, date and due to the cause(s) and manner as stated. 29a. Certifier (Check Cartifying Nurse Practitioner: To the best of my knowledge, death 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1)0064120 M.D 7/29/2012 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Atifzershan AGH 9733 Health Way Drive Barlin MD 21811. Atif Zeeshan 31. Date filed (Month, Day, Year) State park JUL 3 1 2012 Registrar

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G1/02/1961

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Susanne Evans Snyder 8:00 2013 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester 12842 Fox Ridge Court Bishopville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral Months **Director** 218-38-5096 02/09/1941 Maryland 71 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Bishopville 1 Yes 2 X No Maryland Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12842 Fox Ridge Court 21813 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) n and Mental Hygien is marked other th Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Gertrude Wallace Herman Phillip Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau once. 12842 Fox Ridge Court, Bishopville, MD 21813 John Snyder/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗖 Removal from State Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 7/25/2012 Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill Rd Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ MALLONAN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Divisity (or as a nonsequential of cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ponknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? certificate 2 N Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 NO 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 33 PM Andrea Beverly Starkey 2012 Medical Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death County of Death mic cial Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Director 215-35-3840 1 □ M 2 🗓 F -2-1987 MD 25 28a-f show 10a. State ir then "natural", or items 23e or 28a-f sho the Wedloal Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 722A Riverside Road USA death \ 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 XNever Married 2 Married ģ 1 Yes 2 No Specify see Balack Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Depertment of Health and Mentel Hygiene.
Important: If item 27 is merked other then "na any injury or other traumatic event, the Medita once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) JC Penny Sales Associate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Robert Starkey Marlene F. Hayward 19a. Informant's Name/Relationship (Type, Print) Parents 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert & Marlene Starkey, Riverside Road, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Denatten 5 Other (Specify) 7-28-2012 Princess Anne, MD Marks UM Cem 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 Signature of Buneral Service Licenses -00 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ neoplasm malignant disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burial-transit To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician end completely filled in by the funerel director, page 2 should be detached for use es the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 5 Other (specify) Day Year Pregnant at time of death 9 | Linknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 2 1 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1733 Salisbury MD Funaceh -Sheahan 0.0 31. Date filed (Month, Day, Year) egistrar's Signature State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mo*n*th Pa Swope Jamie Patrick Swope 8.20 PM tugus + 001A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Hagerstown Meritus Medical Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 220-64-1440 1 M 2 D F 50 Maryland Usual Residence of Dece 28a-f show 10a. State 10h. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified 1

Yes 2 □ No Md. Washington Cascade 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? must be r Funeral U.S.A21719 25464 Military Rd. items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ь þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X No Page 1 and 2 should be filed within 72 hours after altimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: 3 Widowed 4 Divorced Specify: White "natural" Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) alth and Mental Hygien 27 is marked other the r traumatic event, the Police Officer Law Enforcement 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret T. Kuhn Harry M. Swope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is or other train Gary E. Swope (Brother) 4643 Foxville Rd. Sabillasville, Md. 21780 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department o Important: If any injury or once. 1 Burial 2 X Cremation 3 Removal from State Aug. Smithsburg, Md. Smithsburg Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home DAVIS Smithsburg.Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Sepsis Ph\_si\_ian disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Respiratory Fri Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or as a consequence of) burial-transi End Stage Renal disease with Calciphylaxis and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Preg*n*a*n*t at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day sate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Coronary Artery Disease 1 Yes 2 No 3 Probably 4 Unknown Completed Vasculer Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Peripheral autopsy performed 2 🗌 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Susanna

Johan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG

MO

Registra s Signature

22911

D0071052

Jefferson Blud Smithsburg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Everett Johnsie Shatley, Sr. August 1201 Ρм Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rising Sun Ceci1 Calvert Manor Healthcare Center If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours Min (Month, Day, Year) 184-30-1360 Director 1 🟋 M 2 🗆 F Maryland OCT. 10, 1938 Usual Residence of Decedent other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Pennsylvania Quarryville Lancaster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17566 United States 313 Lamparter Road 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2  $\square$  No 1961 – If Yes, Give 1963 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 X Widowed 4 □ Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Merian injury or other traumatic event, the Merians Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Mushroom Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hattie L. Owens George R. Shatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathlene Mitchell/Daughter 44 Crouse Lane, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 10. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Christ Community
Fellowship Cemetery 2012 4 Donation 5 Other (Specify) West Grove, PA 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 22. Name and Address of Facility 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bladder Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Year Day Pregnant at time of death signed by the a 9 Unknowr 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabotes Type II 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? 24 hours after death.

• Funeral Director: After this certificate function filled in by the funeral director, pag 2 🗆 No Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident work?
1 Yes 2 No 5 Pending injury Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

within 2

To the I

comple

State Registrar 29a. Certifier (Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

101 COLONIAL Way, Rising

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00078354

29d. Date signed (Month, Day, Year)

2191

40180

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				artment of Health and Mental Hygiene	2 25073							
			Registrar  1. Decedent's Name (First, Middle, Last)	rtificate of Death Reg. No. 2 U	2 23313							
ı	Physicia Medic		Mary Lucille Trammel	2. Date of Death  Month  July 26, 20	3. Time of Death							
The same	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of								
	Euporol		Shady Grove Adventist Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Rockville Montgo	DMETY  D. Birthplace (State or Foreign							
	Funeral Director		226-38-8409 1 □ M 2 N F 79 Yrs.	Months Days Hours Min. (Month, Day, Year)	Country)							
	how how at	Ļ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le		/irginia							
	farylar Ba-f s tified	Director	MD Montgomery Boyds		1 ☐ Yes 2 No							
	the N		10e. Street and Number	10f. Zip Code 10g. Citizen of Wha	at Country?							
	h with ns 23,	Funeral	15426 Barnesville Road	20841 USA								
36	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	5	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, \	American Indian, White, etc.							
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215	in 72 h e. ian "n Medi	dmo	(Specify only highest grade completed) (Give	dent's Usual Occupation ikind of work done during most of working O NOT use retired) 16b. Kind of Busin	ness/Industry							
21	d within lygiene. <b>ther tha</b> nt, the N	a a	10   Min		Ministry							
Maryland 21215-0036	ould be filed nd Mental Hy marked oth matic event	To B	17. Father's Name (First, Middle, Last) William A. Corbin	18. Mother's Name (First, Middle, Maiden Surname)  Lucy Pearl Tates Corl	hin							
ary	: 1 and 2 should be of Health and Ment: fitem 27 is marked r other traumatic e			ng Address (Street and Number or Rural Route Number, City or Town, State								
	ealth am 27 i			S Sugar Cane Lane, Gaithersbur	rg,MD 20882							
ore	ge 1 au t of H If ite or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposering Cremetery, cre									
Baltimore,	permit. Page 1 Department of Important: If i any injury or o		4 Donation 5 Other (Specify) Resthaven N		ck,Maryland							
Ba	permi Depar Impo any ir			2. Name and Address of Facility Lyles Funeral Se 30 S. 20th Street, Purcellvil								
١.,			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death							
	Medical	9	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	is s	Onset and Death							
	Examiner		cardeopulmonary arrest									
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	execut an and rial-tra	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):	clostridium difficle colitis								
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687	certifica Iding p	η/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	200d Pote o	f delice.							
P.O. Box 687	res that the death certifica signed by the attending p d be detached for use as t	sicial	in the past 12 months?  1 Live Birth 2 Fetal death 3 in the past 12 months?  1 Pregnant at time of death 5 in the past 12 months?	Ectopic pregnancy Other (specify) Month	Day Year							
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ds, P.	requires the been signed should be d	Completed by Physician/Me	pneimonia		obacco use contribute to the cause of death?  Yes 2 X No 3 Probably 4 Unknown							
Division of Vital Records,	law requi has been ie 2 shoul	mplet		autopsy prior	e autopsy findings available							
E R	n: The ificate or, pag	OO e	25. Was case referred to medical		Yes 2 XNo							
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of	ng Ph fiter thi uneral		27. Manner of Death 1   Natural 5 □ Pending (Month, Day, Year)  28a. Date of injury (Month, Day, Year)  injury		pecny							
sion	or Attendi after death Director: A I in by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No								
ÖĶ	al or A s after al Direct ed in by		4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f. Location (Street and Number or City or Town, State)	r Hural Houte Number,							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invest	occurred at the time, date and place, and due to the cause(s) and manner a digation, in my opinion, death occurred at the time, date and place, and due to death occurred at the time, date and place, and due to death occurred at the time, date and place, and due to the cause(s) and manner as the time, date and place, and due to the cause(s) and manner as the cause (s) and manner as the cause	the cause(s) and manner stated.							
			29b. Signature and title of certifier  Fell Cells	29c. License number 29d. Date signed (M								
	5		30. Name and address of person who completed cause of death /Itom 22a) (Type I	71323 1/26	112							
			Usha Yenigalla 9901 Medical Cen	ter Drive Rockville, MD 2085	0							
	Stat Registra		31. Date filed (Month, Day, Year)  JUL 30 2012  32. Registrar's Signature	ter Drive Rockville, MD 2085								
	negistra	л	AOF A COLE COMMO IN IL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 1440 M Maureen Catherine Thomas 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL TENINSULA MADRAL KICHTICS Center 342156414 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days Months Hours Director 220-52-8547 1 M 2 F 63 07/07/1949 New York th and Mental Hyglene. 27 Is marked other then "neture!", or Items 23e or 28e-f show treumetic event, the Modical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Somerset Princess Anne 1 Yes 2 No 10f. Zip Code 21853 10e. Street and Number 10g. Citizen of What Country? United States 10665 Clarence Barnes Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 72 hours efter Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 ☐ Divorced If Yes, Give Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Verizon, Communication 12 Office Administrator 8 17. Father's Name (First, Middle, Last)
Ted Brown 18. Mother's Name (First, Middle, Maiden Surname) ည Anne Heron Jenkins permit, Pege 1 and 2 should by Department of Health and Mer Importent: If item 27 is mark eny Injury or other treumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5619 Belle Aire Road, E. New Market, Md. 21631 Daughter Lisa Brooks 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State St. Peters Cemetery 08/01/2012 Oriole, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hinman Funeral Home M00295 1673 Somerset Ave. Princess Anne. 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Imm Vate Cause (Final Onset and Death Small Cell Physician/ cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami sicien and burlal-transit Hospital or Attending Physicien: The lew requires thet the death certificate be executed 24 hours after death.
Funerel Director: After this certificate has been signed by the attending physicien and Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physicien for use as the burla Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death tor: After this certificate has been signed by the the funeral director, page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Be B 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) 1 ☐ Yes 2 🔏 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🔏 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number MD D0070129 07-29-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, SALISBURY MD MICCUMION 100 EAST CARROLL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 31 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 25975 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hilda Williams Taylor 0605 M 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehabilitation Nursing Ctr. 5. Social Security Number 6. Sex 17. Age (In vis. last hithday) Wicomico If Under 1 Year If Under 24 Hrs Hours Min **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country) Director 217-05-4036 1 🗆 M 2 🔀 F 07|06|1919 Marvland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6272 Westbury Drive 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 X Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bookkeeper Poultry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Issac Samuel Williams Cora Mae Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Taylor son 6272 Westbury Dr., Salisbury, Maryland 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Wicomico Memorial 4 ☐ Donation 5 ☐ Other (Specify) 07 30 2012 Salisbury, Maryland Park 21. Signature of Funeral Service Licensee Holloway Funeral Home P.A. 501 Snow Hill Rd., Sailsbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Day 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γq To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been six completely filled in by the funeral director, page 2 should Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No ၉ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Hornicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number. City or Town, State Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie ess of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M 5302 (HINABERRY DR. SALISBURY, MID 21801 050

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Richard Alan Williams July 7:58 A M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 106 Vaughn Ave. Greensboro Caroline 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
Dec. 3, 1 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 🔀 M 2 🗆 F Days Min. **Director** 63 Dec. 1948 215-54-0072 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No Caroline Greensboro 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumation." items 23a 106 Vaughn Ave. 21639 USA 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pressman graphics company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ Richard Seymour Williams Blanche B. Chmiel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise J. Williams/ wife 106 Vaughn Ave.; Greensboro, Maryland 21639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home P.O. Box 160 23a. Part 1. Ent 1 the disease, or complications that laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) stati Esophagial 8mos Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to force a numericannel off cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident 2 No Investigation Suicide Could not be 3 L Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours Medical 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature

30. Name and addre

and title of certifier

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erson who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 0511 AM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL Medical Center TENINSULA SALISBURY HICOMICO Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours Min. (Month, Day, Year) Director 1 M 2 F or 28a-f show within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married δ 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed If Yes, Give NHITE 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 i ond Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) æ 17. Father's Name (First, Middle, Last) Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health end Ment Important: If item 27 is marke any injury or other traumatto 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) . Fed MD 21632 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 12 ML 21. Signature of Funeral Service Licensee 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 4 cars Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Dause (Disease or injury sician and burial-trans that initiated events Due to (or as a consequence of): anding physician are use as the burial Physician/Medical Box 68760 attending p IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
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To the Funeral Director: After this
completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 \subsection Suicide 6 ☐ Could not be 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier DO51359 2329 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALIBURY, MJ 218:4. 1415.5. DIVISIONS 7, NATES AN.

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Registrar

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31. Date filed (Month, Day, Year)

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	Funeral Director		5. Social Security Number 220-84-1962 Usual Residence of Decedent  6. Sex 1   M 2   F	7. Age (In yrs. I	ast birtho	Months Days	If Under 24 Hrs Hours Min		th ay, Year)	Cour	place (State or Foreign try) yland	
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lary	should be file and Mental H is marked of raumatic ever		19a. Informant's Name/Relationship (Type, Print)		19b. l	Mailing Address (Street					Code)	
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Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	n State	emetery,	um Churc	h 8-	Date - 4 – 1 2	Loti	ation - City or To		
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. Box 68760	I he law requires that the death centincate be rate has been signed by the attending physic page 2 should be detached for use as the by	Physician/Medical	F FEMALE: 23c. If yes, or in the past 10 months?   1	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	y		236	d. Date of delive	ery Day Year			
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n of	ding P th. After t funera	cate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	of injury orth, Day, Year)	28b. Tim inju	ry work	≀at ? Yes 2 □ No	28d. Describe h	ow injury o	w injury occurred		
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_	Io the Hospital or within 24 hours afte To the Funeral Dir. completely filled in	Medical	29a. Certifier 1 Certifying Physician: To the (Check only one) 3 Certifying Nurse Practitions	sis of examination	n and/or ir	ivestigation, in my opinic	n, death occurred	at the time, date a	nd place, an	id due to the cau	se(s) and manner stated. I	
	Nith		29b. Signature and title of certifier  Samm	ans h	10	29c. License	2472	_		igned <i>(Month, E</i>	Pay, Year)	
J	12		30. Name and address of person who completed can Sovah Sammas HO	se of death (Item	23a) (Typ	- ATT A	Baltim	men.	10 2	2020	\	
**	Stat Registra	_	31. Date filed (Month, Day, Year)  JUL 3 0 2012	Redistrar's Signat	d.	park						

Amend #18 per FD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Ude 20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ambr ·da Jorche reenWood HVenue 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 1 M 2 □ F Months. Days Min. (Month, Day, Y Director Usual Residence of Decedent or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Dorchester 1 Yes 2 No Mbridge 10e. Street and Number 10f. Zip ode 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 12 Yes 2 12 No 1943

If Yes, Give
Year or Dates. 1946 Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced ack 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Stodi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) eatle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GreenWoo 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) HUrlock 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ambridge 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia. or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Gastric denocarcinomo disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 g Unknown 2 🗌 No s been signed by the should be detached a Unknown Part II. **Other significant conditions** contributing to death but not resulti*n*g i*n* the u*n*derlying cause given i*n* Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 N 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 🗌 Yes Other: မှ 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day Year) D53253 MD 2012  $\mathcal{B}^{\times}$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY Sniezek MD 3683 Choptank Road, Preston, MD 21655 31. Date filed (Month, Day, State JUL 3 1 2012 Registrar

Box 68760

Records,

**Division of Vital** 

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of N	/larylan				and M	1ental Hy	giene	0010	05000
			Registrar  1. Decedent's Name (First, Middle, Last)			Cer	tificate c	of Death			Reg. No.	2012	25980
Physi Me	iciar edica	ian/ Verna Ernestine Willey								2. Date of Dea Month July	2 <sup>Day</sup>	2012 ear	3. Time of Death 8:47 a.M
Exa	mine	er	4a. Facility Name (if not institution, give str					n, or Location			4c. C	ounty of Death	
Tan Tan			5051 Bucktown Ro		ao (In vre k	ast birthday)	If Under 1 Ye	mbridge ear   If Under		8. Date of Birt		Dorche	
Fune Direct	tor		224 42 242	M 2 🛣 F	81	Yrs.		ays Hours	Min.	(Month, Day Feb. 20	, Year)	Count	olace (State or Foreign try) laware
land show		흐	10a. State 10b. County		10c. City	y, Town or Lo	cation	,				1	0d. Inside City Limits
Mary 28a-1			MD Dorchest	er		Cam	bridge						1 🗌 Yes 2 🕱 No
with the 23a or st be r		Funeral Director	10e. Street and Number 5051 Bucktown Road				10f. Zip Cod	21613			10g. Citize	en of What Coun USA	try?
Jeath vitems		Fun		2. Was Decedent	t Ever in U.S		Vas Decedent	of Hispanic Ori	gin? (Spe	cify Yes or No-	14	. Race - Americ	
Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		ed by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces  1 ☐ Yes 2 ☑  If Yes, Give  Year or Dates.	No No			No Specify:		nican, etc.)	Sp	Black, White, e	ite
15-0 2 hou "natu		plet	15. Decedent's Educ (Specify only highest grade			(Give k	ent's Usual Oc	ne durina mosi	t of worki	na	16b. Kind	of Business/Inc	lustry
2121 within 7 giene. er than		Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	life. DO	D NOT use retii	carrie		Ŭ	U.	S. Gove	rnment
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam		lo Be	17. Father's Name (First, Middle, Last) Ernest Wheatley							(First, Middle,		rname)	
lary			19a. Informant's Name/Relationship (Type	Print)		19b. Mailin	g Address (Str	eet and Numbe	er or Rura	Route Number	; City or To	wn, State, Zip C	ode)
Magath tealth im 27			Eldridge M. Willey	hus	band				d, Ca	mbridge	e, MD	21613	
nord Hage 1 age 1 age 1 art of H		1	20a. Method of Disposition  1 🕱 Burial 2 🗆 Cremation 3 🗀 Re	moval from Stat	e c	emetery, crem	sition (Name of natory or other r Mem.	place)		ate		ation - City or To	·
altin mit. Pa spartme portan y injury	ce.	ŀ	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Theensee		DOL			dress of Facilit	7/30			bridge, Home P	
a ge e	6	4	1 B 10.7						, Can	bridge.	, MD	21613	
⊸ Phụ i i	16.31		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that cause cause on each lir	ed the death ne.	/		dying, such as	cardiac o	respiratory am	est,		Approximate Interval Between Onset and Death
Medic Examin	al	1	disease or condition resulting in death) a.	Due to (or as	a consequ	ence of):	ary o	17/1	22)			-	
1. m.h			Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):										
60  te be executed hysician and the burial-transit		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.										
<b>50</b> te be executed nysician and he burial-transi		alcal E	resulting in death) Last	Due to (or as	a consequ	ence of):							
3760 ficate b g physia as the k			d.								_		
ox 6876 eath certificat attending ph			F FEMALE: 23b. Was decedent pregnant in the past 12 months?	. If yes, outcome 1  Live Birth		Ideath 3	Ectopic pregn				230	d. Date of deliver	·
of Vital Records, P.O. Box 6870  Physician: The law requires that the death certifica  this certificate has been signed by the attending pl  gral director, page 2 should be detached for use as t		r ilysiciali / ivie	1 Yes 2 No 9 Unknown	4 Pregnant 9 Unknown		eath 5 🗌	Other (specify	)				Month I	Day Year
s, P.C res that signed to the det		2	Part II. <b>Other significant conditions</b> contr	ibuting to death	but not resu	ulting in the ur	nderlying cause	e given in Part I	l.	23e. Did to	4		e cause of death?
ords, require been sign										24a. Was a			sy findings available
<b>/ital Records,</b> sician: The law requires certificate has been sig		nataidiiina								autop: perfor 1  Yes	med?	prior to com death? 1 \( \sum \text{Yes} \) 2	pletion of cause of
Vital ysician: s certifical director,			25. Was case referred to medical examiner?	pital:				. Place of Deat	h (Check		Z. K. S. T. T. S. S. S. S. S. S. S. S. S. S. S. S. S.		
Physical direction		2	1  Yes 2 No	1 Inpat		ER/Outpatient 28b. Time of	3 🗆 DOA					Other (Specify)	
ttending I death. stor: After y the funer			Natural 5 Pending Accident Investigation	(Month, Da	ay, Year)	injury	l w	njury at vork? Yes 2		8d. Describe ho	w injury o	ccurrea	
Division of Vital al or Attending Physician: s after death. al Director: After this certific ed in by the funeral director			3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, et	jury - At hor tc. (Specify)		et, factory, offic	се	2	8f. Location (St City or Town		umber or Rural F	Route Number,
Division of To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	100	רוונים	29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner	an: To the best o	f my knowle	edge, death or	ocurred at the t	time, date and	place, and	d due to the cau	use(s) and i	manner as stated	d.
o the Frithin 2 or the Fromplet	Ä	≦  -	only one) 3 Certifying Nurse F	ractitioner: To the	ne best of m	y knowledge,	death occurred	at the time, date	e and plac	e, and due to th	e cause(s) a	and manner as st	ated.
4	0	ľ	Van lle				45	7779=	3		7/21	igned (Month, Da	ay, rear)
	الا	3	30. Name and address of person who com	oleted cause of	death (Item	23a) (Type, Pr	int	irster	Av	e Svit	-) (	2 mbn a	1. MP21612
	tate		11. Date filed (Month, Day, Year)	32. Registr	rar's Signatu	1. pa	100	10) 4	111	114	<u> </u>	arrivio	CINIONITY
Regis	strar		JUL 3 1 2012	Caron	u p	- 14	# * ·						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month S 3012 Janis Eileen Werner 1008 PM Medical Facility Name (if not institution, give street and number Examiner 4c. County of Death 4b. City, Town, or Location of Death astal icomic OSQUE isbur Sal . Social Security Numbe If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Days Director 218-42-5807 1 M 2 X F Dec, 24,1946 Maryland 65 Usual Residence of Deced "natural", or items 23a or 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho treumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Dorchester East New Market 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21631 6322 Snug Harbor Road USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 Divorced 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) end 2 should be filed within Health and Mental Hygiene. tem 27 is marked other tha Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hazel Dukes John Granville Wheatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6322 Snug Harbor Road, East New Market MD 21631 Stanley J. Werner/Husband permit. Page 1 end 2 Department of Health Important: If item 27 eny injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Of Delmarva 7/27/2012 Delmar, Delaware Sign tury of Functal Service Lio 22. Name and Address of Facility. Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market MD reased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of line. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one sause on part Immediate Cause (Final Physician/ MRTASTA DISRASR Onset and Death TIC KIDNRY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sis completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 2/ENO 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 1 Yes ZENo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No 9 Natural 5 Pending injury 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 8410 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6HUMM 150 31. Date filed (Month, Day, Year) State 32 Registrar's Signature Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Deshan Wilme	r	1-For State Registrar  1-For State  1-For State Registrar  State of Maryland / Department of Health and Mental Hygiene  1-For State  Certificate of Death	e Reg. Ne	20	12 259
Physician/ Medi Exami		Month	of Death		3. Time of Death
-Adm	1101	4e. Fecility Name (if not institution, give street and number)  4b. City, Town, or Locetion of Death	19, 2012	4c. County of Death	1423 hrs
		322 Walnut Street Church Hill		Queen Anne's	
Funeral Director		Months Days Hours Min	of Birth (Mf	Cor	hplace (State or Foreign untry)
		Usual Residence of Decedent	ne 7	1963 M	aryland
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
nyland ta-f she	ctor	o NI) Queen Anne'S Church Hill 101. Street and Number 101. Zip Code	100 C	itizen of What Coun	1 Yes 2 No
the Ma a or 28	Funeral Director	322 Malnut Street 21623	, , og. 0	71 < 1	u y r
th with	neral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes 1 Never Married 2 Married Armed Forces? 14. Was Decedent of Hispanic Origin? (Specify Yes 15. Was Decedent of Hispanic Origin? (Specify Yes 16. Armed Forces?	or No-	14. Race - Americ White, etc.	can Indian, Black,
ter dea			,	1.	2cK
ours af	Completed by	16a. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/In	
36 nin 72 h	plet	Elementary/Secondary (0-12)  College (1-4 or 5+)	, le		-
5-00 led with tygiene other	Com	17. Father's Name (First, Middle, Last)  Customer Service Ref	Idle, Maiden	estau Surname)	rant
121 dbe fil fental F sarked event, 1	o Be		Ans	n Ric	h
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Bygiene Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	۲	and the state of t	te Number, ( `a Sün	City or Town, State,	Zip Code) M.h> 17, 38
re, N : 1 and f.Health f.item	Ì	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 1 Deurial 2 Cremation 3 Removal from State crematory or other place)	20c	. Location - Citý or	Town, State
Page: ment o tant:		4 Donation 5 Other Specify Chesterfield Clemetery 7/27/	12 4	entre vi	Ile, MD.
Balti pernit. Departn Importu injury c		21. Signature of Funeral Service Licensee  22. Name and Address of Fedility Henry Funeral Hon	ne, P.	,A,	Mb 01/.13
Physician	1	23á. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory feiture. List only one cause on each line.	arrest, sho	ck, or heard	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease			Between Onset and Death
•		Due to (or as a consequence of):  Sequentially list conditions,  b			
	niner	of any, leading to immediate — Due to (or as a consequence of).  Cause. Enter Underlying Cause  (Disease or injury that initiated C			
red red	Examine	events resulting in death) Last us to or as a consequence or).			
1760, ficate be executed g physician and the bural - transit					
3760, ficate be g physic s the bur	5 L	IF FEMALE: 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the	23	d. Date of delivery	
Box 68 e death certif the attending ed for use as	iclan	2 Was decedent pregnant in the past 12 months?      1	. 1	Month Da	y Yeer
P.O. Box 687 s that the death certifi gred by the attending	Physiclan	1 Yes 2 X No 9 Unknown 9 Unknown 9 Unknown 23e.1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Did tob soci	use contribute to th	(1, 1)
, P.O.	巨	Diabetes Mellitus; Hypercholesterolemia; Obesity			bly 4 Unknown
ords, w requir sbeen s should	lete	24a. \	Was an autopsy		psy findings available impletion of cause of
Reco The law cate has	Completed	1	performed? Yes 2X	death? lo 1 Yes	
Division of Vital Records, tal or attending Physician: The law requirers after death.  The law require all birectors: After this certificate has been side on by the funeral director, page 2 should be an by the funeral director, page 2 should be a by the funeral director, page 2 should be a sho	B	25 VYas case referred to medical 26 Place of Death (Check only one) examiner?			
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Sion tttendi death. ctor: A	Įġ.	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year) 1 Yes 2 No			
Divis	Certification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Locat or To	ion (Street a wn, State)	and Number or Rural	Route Number, City
		Zea Centrer - Tarana - La La La La La La La La La La La La La			
To the withing To the complete	ᄝ	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.  29b Angulature and title of certifier			
\		29b. Rigotature and title of certifier  29c. License number  O.C.M.E.	- 1 -	Date signed (Monti uly 20, 2012	n, Day, Year)
	-	30 Name and address of person who completed cause of death (Item 23a)			
Sto.		Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Dey, Year) 32 Jegistrar's Signature			
Sta Registr					
DHMH 17 Rev 1/200	1	ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month Day Leo George Welch 4:25 AM 07-22- 2013 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Coastal Haspice Salisbury Wicomico 4 the Lake 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 216-18-2390 Director 88 1 X M 2 🗆 F 11/19/1923 Maryland Usual Residence of Decedent 23e or 28e-f shov 10c. City, Town or Location traumetic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland 1 🗆 Yes 2 😾 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1306 Hazel St. 21804 USA end Mentei Hygiene. Is merked other then "neturel", or Items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Grocery Be Pege 1 and 2 should be flied 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leo George Welch Sr. Velma Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heeith e Melodye L. Payne/Daughter 36369 Robin Hood Rd., Delmar, DE 19940 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Springhill Memory 7/28/2012 Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

Approximate Hebron, MD 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician 100440 Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. First Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): signed by the ettending physicien end d be deteched for use as the buriel-trensit To the Hospital or Attending Physicien: The lew requires thet the deeth certificete be executed within 24 hours effer deeth.

To the Funerel Director: After this certificete has been signed by the ettending physicien end completely filled in by the funerel director, page 2 should be deteched for use as the buriel-trensit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 1 Yes 2 THO 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certificate: To Pinpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1- Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 1005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33

State Registrar 31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kenneth Month Day Year 2 Young 07 27 Laurence 4:35 Am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3158 Gracefield Road, #401 Silver Spring P.G. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Hours Min. (Month, Day, Year) Director 092-20-9919 1 🖾 M 2 🗆 F 84 Yrs. 20, 1927 NY eho 10a. State 10b. County ir then "natural", or iteme 23a or 28e-f eho the Medical Examinar must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD P.G. Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3158 Gracefield Road, #401 20904 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. Completed by Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hyglene. ent: If item 27 is marked other then "natural", or X Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 K No Specify: If Yes. Give 3 Widowed 4 ☐ Divorced Year or Dates. Korean 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Organizer Labor Union traumatic event, 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Laurence Eugene Young Rosalie Boehm Maibrunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Young/Son 3822 Gramercy Street, NW, Washington, DC 20016 20a. Method of Disposition 20b. Place of Disposition (Name of Ju1<sup>Date</sup> 28 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan
Crematory ö 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or once.  $\bar{2}01\bar{2}$ 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Fu
500 University Blvd. Funeral Home Inc. d. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ Multiple Myeloma vrs Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). attending physician and a for use as the burlai-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ Chronic Renal Insufficiency, Pulmonary Disease Division of Vital Records, Completed 1 Yes 2 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 XNo 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 🖾 No Other: |요 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural
2 Accident 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year, 9+1 D35996 July 26, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2730 University Blvd. W., #400, Wheaton, MD 20902 Linda M. Burrell, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 30

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10 state of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ANSFIELD Physician/ Month 1126 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospice of the Chesapeake Harwood Anne Arundel If Under 1 Year If Under 24 Hrs. . Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 141-28-2144 1 ☑ M 2 ☐ F 78 Oct 12, 1933 North Carolina ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director MD Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 709 Glenwood St. Apt 406 21401 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Armed Forces 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) laborer shipyard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Hattie Alston Mansfield Alston Sr. permit. Page 1 and 2 should Department of Health and Mi Important: If item 27 is mari any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217 Bowie Ave; Annapolis, MD 21401 Patty Alston - sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify)in state Sign ture of uneral strice bensee wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Priset and Death Physician, UNG disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 2 🗌 No 1 Yes 2 N 1 🗌 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certification completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) Signature and title of certific 29d Date signed (Month, Day, Year) Name and address of completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Percy A. Arteen 0: 09 Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arundel Future Care Chesapeake Arnold Anne Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth April 1, 1940 Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 XM 2 □ F 267-80-9985 72 Mousel. Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Funeral Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified MD Anne Arundel Pasadena 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3561 Brickwall Lane 21122 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examit Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 Federal Government College (1-4 or 5+) Language Analyst 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Apcar Joseph Arteen Najibah Daood Hattab 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natalie Arteen-Daughter 210 Benfield Rd. Severna Park, MD 21146 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition August 16, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Parkville, Maryland 2012 Donation 5 Other (Specify) Sia of Funeral Service License Evans funeral chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician rebrovascular ease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confidence. attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Month Year Yes 2 No signed by the a d be detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of D-th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or invention in my artifact death. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Fractioner: To the best of my knowledge, deb 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ust 10, m. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

niucroville

Veteran.

8501

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :25 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death MIRC Anne PO thna If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 □ F Months (Month, Day, Year) Director INFANT Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ashingto 1 Xes 2 ☐ No 10e. Street and Number 10f. Žip Code 10g. Citizen of What Country? Funeral 1th Street South 0033 12. Was Decedent Ever in U.S 11. Mariţal Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 ☐ Married þ Maryland 21215-0036 1 ☐ Yes 2 Ø No 3 Widowed 4 Divorced Jack Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) INFANT Elementary/Seconday (0-12) INFANT INFANT Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ ernick Michelle ominique ansom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4351 4th Street Southeast OMI nique kner mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Ly ...
Signature of Funeral Signature Constitution 1 Puneral Signature Cons state 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) more Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in listed assets or lingury) Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death 03 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has townileted filled in by the funeral director, page 2 townileted filled in by the funeral director, page 2 townileted filled in by the funeral director. autopsy 1 Yes 2 - No Yes 2 4 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ļè 2 - No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and addre person who completed cause of death (Item 23a) (Type, Print) rest 21620 31. Date filed (Mont Registrar's Signature State AUG 1 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2598 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 933 A M rad a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAMOZHAN HOSIPHA BALTIMORE 5. Social Security Number 244 - 50 - 335 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Country) 8. Date of Birth Months Days Hours Min Director 3.5 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits or 28a-f BAHIMORE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with ti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a o Funeral 956 ARRONNE ZIZIX USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: 3 Widowed 4 □ Divorced BIACK Specify: other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) HOSIPHAL College (1-4 or 5+) JERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ lon koe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BURNIN MDZIZ39 DA DREW DAUGINE 1604 DA HIMURE foold 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, injury 21/2012 DA HIMORE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fu 22. Name and Address of Facility VAUC SVCS 490540RX ROOD BAILIMOREMI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury and that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): signed by the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 21 No Month Dav Year significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' ျှ 1 Tes 2 No Other 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie

DHMH 17 Rev 7/2009

State

Registrar

and address of person who

5

31. Date filed (Month, Day, Year)

AUG

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Marlo B. Barden		- For State	tate of Maryla		artment of rtificate of		nd Menta	l Hygiene	Reg. N	20	2 2 5 9
Physiciar Medical Examin	1/	Registrar  1. Decedent's Name (First, Midd  Marlo Burnade	dle,Last) ette Bard	en				2. Date of Month Augus		v Year	3. Time of Death 2150 hrs
		4a. Facility Name (if not instituti 7901 Laurel Lakes C	ion, give street and nu		4	b. City, Town, c	r Location of D	eath		4c. County of Death Prince George	
Funeral Director		5. Social Security Number 242-90-9752	6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Ye Months Da				M/DD/YYYY) 9. Bird Foreig , 1952 Sp	
nd thow any es.	Ţ	Usual Residence of Decedent 10a. State 10b. County 1ary1and Prince	ce George'		Town or Locati	on					10d. Inside City Limits 1 X Yes 2 No
the Maryland a or 28a-f show tified at once.	Director	10e. Street and Number 7901 Laurel I	Lakes Ct.	#123		10f. Zip Code 2070	7			Citizen of What Cour	try?
er death with	Funeral	11. Marital Status 1 Never Married 2 N 3 Widowed 4 Di		2 X No	If Ye	s Decedent of Hes, specify Cuba	n, Mexican, Pu			14. Race - Ameri White, etc.	can Indian, Black,
2 hour	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	or Dates: ecify only highest grad	le completed)	16a. Decedent	t's Usual Occupa ost of working life	ition (Give kind e. DO NOT use	d of work done e retired)	16b	o. Kind of Business/I	
21215-0036 uld be filed within 7 Mental Hygiene c event, the Medica	Ee Com	17. Father's Name (First, Middle Elihue Barden			Data (	Operator	18.Mother's N	lame (First, Mid Owsler	dle, Maide	US News en Surname)	
e, MD 2121 I and 2 should be fileath and Mental Health and Mental Traumatic event,	2	19a. Informant's Name/Relations James Barden	ship (Type, Print) (Brother)		2002 (	Otis St.	, Durh	am, NC	2770		
Pages sent of trut: If		20a Method of Disposition  1 Donation 5 Other S  21 Signature   Funeral Service		om State	crematory or oth echwood	Cemeter	у 8	Date - 14-201	2	c. Location - City or Durham, N	
Balti Bermit. Departu Imports injury 6		2 a. Part I. Enter the disease, or	# ###		55.		St., A	.1exandr	ia,	VA 22310	Approximate Interval
/Medical Examiner		failure, List only one cause Immediate Cause (Final disease or condition resulting in death)	<sub>a.</sub> Atheroscler	otic Cardiova consequence of		ease					Between Onset and Death
ted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of							
oe execulician and inial - tra	5	UNPENDED	d. AMENDED						I a		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician properey filled in by the funeral director, page 2 should be detached for use as the build cell of the funeral director, page 2 should be detached for use as the build cell of the funeral director, page 2 should be detached for use as the build cell of the funeral director, page 2 should be detached for use as the build cell of the funeral director.	1 yalcıdı ilm	F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 ✓ Un	he 1 Live b	ant at time of dea	2 Feta	al death 3 er (Specify)	Ectopic pro	egnancy	_  2	23d. Date of delivery Month D	ay Year
ords, P.O. B w requires that the d as been signed by the should be detached		Part II. Other significant condi	tions contributing to	death but not re	sulting in the ur	nderlying cause	given in Part I.	_ 1 _	-		he cause of death?  ably 4  Unknown  opsy findings available
Division of Vital Records, tal or Attending Physician: The law requinms after death.  and Director: After this certificate has been sited in by the funeral director, page 2 should be deficient. To Be Commission	e completed by	25. Was case referred to medica	al			26.Place	e of Death (Ch	1 1	autopsy performed es 2	? death?	ompletion of cause of
ing Physicia After this ce Unertal direct	2	examiner?  1 Yes 2 No  27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of In		Other Nu	ursing Home 5		dence 6 🗹 Other:	Scene
Division of spiral or Attending Pt spiral or Attending Pt nours after death.  neral Director: After if filled in by the funeral	Callon		ding estigation (Month,	Day,Year) of Injury - At ho	me, farm, street		Yes 2 No				al Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide dete	ermined (Specify)  Physician: To the best	of my knowledg	e, death occurr	ed at the time, d	ate and place,		vn, State) cause(s) a	and manner as state	d,
To the How within 24 h To the Fur completely	Medic		aminer: On the basis of and manner st er		nd/or investigation	on, in my opinior		ed at the time,		d. Date signed (Mon	
	3	30. Name and address of person	who completed caus			O.C.		24222	Au	ugust 3, 2012	
Stat	~	Ling Li, MD Assista		gistrar's Signatur		sileet, bal	aniole, MD	21223			
Registra  DHMH 17 Rev 1/200	_	AUG 1 5 20	MZ Com	v fl.	ORIGINAL				OCME		
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			For State	State of Ma	aryland / I				lental Hy	giene -	
			State Registrar	1		Certificate	e of Dea	ath		Reg. No. 20	2 25991
ı	Physici		1. Decedent's Name (First, Middle Marie Yolande	,					2. Date of De	eath Day 2 2%	3. Time of Death 12:05 a M
N.	Medi Exami		4a. Facility Name (if not institution,	give street and number)		4b. City,	Town, or Loca	ation of Death	2 10gc	4c. County of D	11,5,00
	F		CIVISTA Med 5. Social Security Number	lical (ent	er	1 / 1	Lat	lata		Cha	rles
	Funeral Director		098-48-1107	1 D M 2 17 F	(In yrs. last birt	hday) If Under Months Yrs.		Jnder 24 Hrs. ours Min.	8. Date of Bil (Month, Da	ay, Year)	Birthplace (State or Foreign Country)
	nd now	١	Usual Residence of Decedent 10a. State 10b. County						Nov. 1	, 1935	Haiti
	farylar Ba-fsk tified	Director	MA Norfo	1k	10c. City, Town						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
_	a or 20	٥	10e. Street and Number			10f. Zip	Code			10g. Citizen of What	
-	ns 23 must	Funeral	71 Doggett Circ				:026			U.S.A.	
9	er dea or ite miner	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	12. Was Decedent Every Armed Forces?  1  Yes 2 X		13. Was Decede If Yes, speci	ent of Hispani ify Cuban, Me	ic Origin? (Spe exican, Puerto	cify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
21215-0036	urs aft tural", al Exa	ted h	3 X Widowed 4 Divorced	If Yes, Give Year or Dates.		1 🗆 Yes 2	2 X No Sp∈	ecify:		Specify: B	lack
15	72 ho in "nat Medica	Completed	15. Deceden (Specify only highe	t grade completed)		Decedent's Usua (Give kind of work	k done during	most of worki	ng	16b. Kind of Busine	ss/Industry
212	within giene. er tha		Elementary/Secondary (0-12)	College (1-4 or 5+	-)	Nutriti				Hospita]	L
Maryland	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Li Cesar Souvinir	ist)						Maiden Surname)	
ıryk	ould b nd Mer mark matic		19a. Informant's Name/Relationsh	n (Time Print)					Compeze		
	d2sh ¤althar n27is ertrau		Shirley Bouber		3	100 Esse	r Pl.,	wmber or Rura Waldo	Route Numberf, MD	r, City or Town, State, 20603	Zip Code)
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. Place of cemeter	Disposition (Name y, crematory or oti	e of her place)	D	ate	20c. Location - City	or Town, State
Iţim	artmen ortant;		4 ☐ Conation 5 ☐ Other (Sp. 21. Signa ure of Free eral Service Li	ecity)	Oak La	wn Cemet		8/18/		Boston,	
Ba	Depar Impol any ir		Signature of Priveral Service L	Vellum		Metrop	Address of F Olitan ine St	Funera Alex	1 Serv	ice , VA 22310	
			23a. Part 1. Enter the disease, or on shock, or heart failure. List or	complications that caused to all you cause on each line.	he death. Do n	ot enter the mode	of dying, such	h as cardiac or	respiratory an	rest,	Approximate Interval Between
2000 E	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a Galle	Pleddy	er Ca	ncei				Onset and Death
	Examiner		resulting in death)	Due to (or as a	consequence o	f):	The same of the sa				
	+	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence o	ij.		_			
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0	death certificate be executed re attending physician and ed for use as the burial-transit	dicalE	resulting in death) Last	Due to (or as a	consequence o	7):					
68760	ificate ig phys	Medi	IF FEMALE:	d				_			
9 X	eath certifica attending pl	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	Fetal death	3 🗆 Ectopic pr	egnancy			23d. Date of o	
. Box		Physician/Me	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 ∐ Pregnant at t 9 □ Unknown	ime of death	5 Other (spe	cify)			Month	Day Year
P.0			Part II. Other significant condition	s contributing to death but	not resulting in	the underlying ca	iuse given in F	Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds,	requires been sig should b	Completed by							1 🗆 🕆	/es 2 □ No 3 □	Probably 4 Unknown
000	has be	mple							24a. Was a	sy prior to	autopsy findings available o completion of cause of
I R	nysician: The law inscertificate has kindirector, page 2 s		25. Was case referred to medical						1 Tes	med? death? 2 No 1 □ Y	es 2 No
Vita	Physicia this cert al direct	To Be	examiner? 1 ☐ Yes 2 🗶 No	Hospital:	t 2 K FB/Out	patient 3 DOA	Other:	Death (Check		C \( \tau \) Other (0)	~ ~ 1
of	_ = e	ate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	28b. Ti		c. Injury at work?			ence 6 Other (Special Countries)	ecity)
sion	I or Attending after death. Director; After I in by the fune	Certificate:	2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could no	t he		М	1 Tes 2				
Division of Vital Records,	al or A s after Il Direct		4 ∐ Homicide determin	ed 28e. Place of Injury building, etc. (	Specify)	n, street, factory, o	OTTICE	2	8f. Location (S City or Tow	treet and Number or Fi n, State)	ural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check 2 Medical Ex	hysician: To the best of my	y knowledge, de	eath occurred at the	he time, date	and place, and	I due to the ca	use(s) and manner as	stated. e cause(s) and manner stated.
	o the l	ĕ.	only one) 3 Certifying N	urse Practitioner: To the b	est of my knowl	edge, death occur	red at the time	e, date and plac	e, and due to th	e cause(s) and manner	as stated.
-	r s r ō		This a	Theo -		-   D	License numb	9725	)   '	29d. Date signed (Mon	nn, Day, Year)
			30. Name and address of person wh	o completed cause of dear	th (Item 23a) (Ty	/pe, Print)		14.)6	101	00/17/	
	Chat		Duayne my BY. Date filed (Month, Day, Year)	mpson M	Signor	CTarre	++ A	ve L	a Pla	ita, MD	20646
	Stat Registra	_	AUG 1 5 2	)12 Personal Registrar's	J. A	back					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Columbia Howard 6817 Carlinda Avenue 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours Min. (Month, Day, Year) Surabaya, Java 562 28 2862 Director 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director Examiner must be notified 1 🗌 Yes 2 🕱 No Maryland Columbia Howard 10f. Zip Code 5 10e. Street and Numbe 10g. Citizen of What Country? Funeral 23a 21044 U.S.A. 6817 Carlinda Avenue "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: Completed 3 Nidowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Katherine Innes Albert Munson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 street of Health a tant: If item 27 i Columbia, Maryland 21044 6817 Carlinda Avenue Gwen Brown (Daughter) 20a Method of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) 1 🗌 Burial 2 😾 Cremation 3 🗌 Removal from State 8-13-2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Fine / I Servic : Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. oad Columbia, Maryland 21045 5555 Twin Knolls Road eat. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Praysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury and -trans that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-1 Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No the detached g Unknown g 🗌 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 perform 2 3 100 1 🗌 Yes Yes Division of Vital rector, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 1 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 24 hours after death.

Funeral Director: After this ceted filled in by the funeral dire မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No iniury Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INTHICUM SA

State

Registrar

AUG 1 5 2012

. Registrar's Signat

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, John H. Ball 2. Date of Death 3. Time of Death Year Month 7/13/12 Physician/ 8:10pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice, Columbia Columbia Howard 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Social Security Number 116-28-9254 NY **Director** 1 K M 2 - F 75 3/12/37 Yrs 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Town of Webb notified Old Forge NY Herkimer 1 XXes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō ms 23a or must be i Funeral 129 Ball Road 13420 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or Nom If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian 11. Marital Status Armed Forces?

1 XX Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Vietnam or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 60-62 WHite "natural" 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) er than Elementary/Secondary (0-12) College (1-4 or 5+) Construction Builder Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harry James Ball Evelyn LaClair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ball Wife 129 Ball Rd, Old Forge NY 13420 Barbara 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Burial 12 ☐ Cremation 3 ☐ Burial 2 ☐ Cremation 3 ☐ Burial 12 ☐ Cremation 3 ☐ C Waterville Crematory Waterville, 4 Donation 5 Other (Specify) Funeral Service Licensee Victor P. Doda 22 Name and Address of Facility Charles L. Stevens Funeral Home. 1501 E. Fort Avenue, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STAGE disease or condition Medical resulting in death) Examiner 06/2006 Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exam the Hospital or Attending Physician: The law requires that the death certificate be executed thin 3.1 house after about and the burial-tran Due to (or as a consequence of). resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year Yes 2 No been signed by the a should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed?

☐ Yes 2 🗷 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{K} \) Other (Specify Hospice ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director: Ai
completely filled in by the fu 2 🗌 No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License numbe IN MD D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR DLUMBIA Q. ABBBAS SYED 31. Date filed (Month, Day, Year) State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19aState of Many Bunce/Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST RAISSA BARMAK 2012 02:15PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Country) Director 213-35-2197 71 Usual Residence of Deced 07/02/1941 UKRAINE Hygiene. other than "netural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE BALTIMORE 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 GREENWICH PLACE 21208 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. 3 Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with n end Mental Hygien 7 is marked other th COMPUTER PROGRAMMER CONSULTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 AARON BARMAK ADAMSKIY ZEELIY 19a. Informant's Name/Relationship (*Type, Print*) Alexandre <del>ALEXANDER</del> BARMAK / S 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health e Importent: If item 27 is any Injury or other tra BARMAK / SON FAIRMEWS COURT, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
ARLINGTON CEMETERYCHIZUK AMUNO CONG. 08/14/2012 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Breast Physiciani Onset and Death cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of) resulting in death) Last the attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an rs after death. el Director: After this certificate ha lled in by the funeral director, page performed? Yes 2 M No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bowtie$  Other (Specify)  $\bowtie$  SPI  $\stackrel{?}{\sim}$ 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? \_\_1 ☐ Yes 2 ☐ No 5 Pending injury Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) and title of certific 2012 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST TOUSON MO

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

AUG 1

5 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink./Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marttia Baker Aug not 19:40 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A 4b. City, Town, or Location of Death Examiner Raltimore Baltimor 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea 1 / 15 / 60 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 52 **Funeral** Months Days Hours VA Director 1 M 2 XF rel", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland Director MD N/ABaltimore 1X Yes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code 21215 Funeral 2739 Baker St. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc arth 1 ☐ Yes 2 🛣 No If Yes, Give 1 XNever Married 2 Married African Completed by 1 Yes 2 XNo Specify: 3 Divorced than "natural" Amer. Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hospital College (1-4 or 5+) Elementary/Secondary (0-12) Cook 11 1 and 2 should be filed work thealth and Mental Hygi item 27 is maned other other traumaticevent, to Be land 17. Father's Name (First, Middle, Last) William Thomas Baker, Jr. 18 Mother's Name (First, Middle, Maiden Surname) Julia White 19a. Informant's Name/Relationship (Type, Print) Katie Baker/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2739 Baker St., Balt., MD 21215 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State pernit. Page 1 a
Department of H
Important: If ite
any injury or ot Bayview Crematory 8/18/12 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Balt.,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Fune al Service I 23a Part 1. Enter the disease, or of the tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ neumonia Medical resulting in death) Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Duy to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 \( \subseteq \text{ Nursing Home } 5 \subseteq \text{ Residence } 6 \subseteq \text{ Other (Specify)} 1 Yes 2 340 1 Thipatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Pendli, MD 1065718 ,11, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 2401 West Belvedere AVE, BALTIMORE, MD 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 5 2012 Registrar

Baker

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death **Funeral** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months **Director** 55 1 □ M 2 XX 1/23/57 MD show 10a. State 10c. City, Town or Location the Maryland at Director 10d. Inside City Limits must be notified MD N/A Curtis Bay 28a-f Yes 2 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1402 Cypress Street, Apt-6 21226 USA or items Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes > No Specify: 3 Widowed 4 Noivorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) Secretary Metal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James S. Stelmach Sara A. Clifford 19a. Informant's Name/Relationship (Type, Print)
Melissa L. Lippy / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip ( 1402 Cypress Street, Baltimore MD 21226 and 2 s Health tem 27 i permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Holy Cross Cemetery 8/16/2012 4 Donation 5 Other (Specify) Baltimore Maryland Signature of Funeral evice Licensee Victor P. Doda <sup>22</sup> Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore MD 21230 00 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato shock, or heart failure. List only one cause on each line. Approximate Interval Between Onse and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a conseq resulting in death) Last Physician/Medical Box 68760 SE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: မှ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending injury Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

1 5 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patty Arto 426 PM 2012 Medical Uc 0 4a. Facility Name (if not institution, give street and number Examiner Town, or Location of Death 4c. County of Death Baltimore Randal Istown Hospita Jorth west 6. Sex If Under 1 Year If Under 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Director 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Himore MID 1 Yes 2 No 10f. Zip Code 10e. Street and Num ò 10g. Citizen of What Country? ms 23a or must be n Funeral 2122 mondson items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene.

Important: If the m27 is marked other than "natural", or iter limportant: If the m27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Blac 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give and of work done during most of working life. DO NOT use retired) College (1-4 or 5+) wegiver Flementery Be Father's Name (First Middle Last 2 19b. Mailing Ad Zid Code) Baltimore, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) re of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death h sician/ Artherosclerotic Cardiovascula disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to for as a consultence of if any, leading to immedicause. Enter Underlying Examir Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the ed by tl signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy performe death? certificate 2 🗆 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 No ၀ 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5  $\square$  Pending Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of D0063918 10 ho completed cause of death (Item 23a) (Type, Print) eHe Smith 5401 C Name and address of Old Court Road Randallstown, MD 21133 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death - State Registrar 3. Time of Death 2. Date of Death edent's Name (First, Middle, Last) 10:45AM Month 2012 Physician/ homas Medical 4c. County of Death or Location of Death **Examiner** Baltimore tome ursing g. Birthplace (State or Foreign Country) 8. Date of Birth Age (In yrs. last birthday) (Month, Da) Year Months **Funeral** 87 1 ☐ M 2 😿 F 16 Director 10d. Inside City Limits 10c. City, Town or Location fshow 10b. County the Maryland Director 1 Yes 2 No MD Baltimore be notified or 28a-f oreen Spring Ave 10g. Citizen of What Country? Apt 204 10e. Street and Number 21211 Funeral 23a Avenue Examiner must Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban Mexican, Puerto Rican, etc.) items ? 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural". or interming or other traumatic event. Black, White 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Middle, Maiden Surname) Be Famer's Name (First, Middle, Last) ပ္ ames Town, State, Zip Code) Informant's Name/Relationship (Type, Pi Kø lau . Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State જ 4 Donation 5 Other (Specify) 0 ure of Fune al Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardionesania discare Immediate Cause (Final ATHEROSclerotic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death Month Day Year in the past 12 months?
1 Yes 2 No Other (specify) Pregnant at time of death n signed by the at g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 2 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy eral Director: After this certificate has filled in by the funeral director, page 2: 2 🗆 No 1 🗌 Yes Yes 26. Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 100 1 🗌 Yes 28d. Describe how injury occurred 28a. Date of injury 28b. Time of 28c. Injury at work? Manper of Death (Month, Day, Year) injury Natural 5 Pending 1 🗌 Yes 2  $\square$  No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 3 only one) 29d. Date signed (Month, Day, Year) 29b. Sign D0059056 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belt MO Salvic HOR ST

DHMH 17 Rev 06-2011

State

Registrar

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700 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August Physician/ 20 ใช้ 9:50 P M Richard Cochnar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring 14817 Stonegate Terrace 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** Hours Director 706-18-9810 1 🛛 M 2 🗆 F Yrs. 1923 New Jersey Aug 6, 89 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Maryland Director must be notified 1 Yes 2 No Silver Spring MD Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 5 23a Funeral United States 20905 14817 Stonegate Terrace permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced White Year or Dates. 1942-45 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Information Technology Systems Analyst 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Josephine Zatrepalek Robert Cochnar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14817 Stonegate Terrace Silver Spring, MD 20905 Cochnar / Wife Petronella 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Woodbine, Maryland Final Journey Crematory 8/10/12 4 Donation 5 Other (Specify) Signature of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 once 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Years Immediate Cause (Final Physician/ Obstructive Lung Disease disease or condition resulting in death) Chronic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-tran Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: asn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Bipolar Disorder 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy page 2 performed? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: (Month, Day, Year) injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, in by t determined City or Town, State) 24 hours Funeral Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 To the within 2 To the comple 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 9, 2012 D35996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2730 University Blvd. #400 Wheaton, MD 20906 Linda M. Burrell 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ onth OL Medical MOUST 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Symphony Manor Assisted Living Baltimore City n/a Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Davs Hours (Month, Day, Year) Director 217-20-2056 1 □ M 2 🗓 F Yrs. 86 May 14, 1926 Maryland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland **Baltimore** Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 159 Church Lane 21030 death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. Completed by 3altimore, Maryland 21215-0036 within 72 hours after ☐ Yes 2 🖾 No 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Josepartment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event any injury or other traumatic event. Elementary/Secondary (0-12) College (1-4 or 5+) 10 Cafeteria Staff Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albaugh India Staubitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth M. Cole/Son 10508 Samona Road, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Poplar Grove Cemetery 8/14/2012 Phoenix, Maryland Signature | Fun rul Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service Lice | Service | Service Lice | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Service | Servic 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ 2 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last been signed by the attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has filled in by the funeral director, page 2 autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 🗌 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death, To the Funeral Director: After th completely filled in by the funeral 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 06-2011

State

ncrow M

address of person who completed cause of death (Item 23a) (Type, Print)

329

filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			A 101		artment of Health and	Mental Hygi	ene
			State Registrar	Cer	tificate of Death	Re	eg. No. 2012 2000
m	Physicia	ın/	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	0.111100120001
ide.	Medic	cal	Juan Castillo			Aug	11 2012 9:25AM
	Examir	ıer	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Dea	th	4c. County of Death
100	Funeral		Ellicott City Health & Rehab  5. Social Security Number   6. Sex   7. Age //	n yrs. last birthday)	Ellicott City  If Under 1 Year   If Under 24 Hrs	s. 8. Date of Birth	Howard  9. Birthplace (State or Foreign
	Director		266-25-7526 1 × 1 × 1 1 × 1 1 1 1 1 1 1 1 1 1 1 1	Van	Months Days Hours Min	. (Month, Day, )	Year) Country)
D. T.	MC .		Usual Residence of Decedent	90		June 17,19	
	yland -f show ed at	Director		Oc. City, Town or Loc Columbia	cation		10d. Inside City Limits
	e Mai r 28a notifi	Jie I	Maryland Howard  10e. Street and Number	- WILLIDIA	Tank 7: Out		1 Tyes 2 X No
	ith th		5631 Thunder Hill Road		10f. Zip Code 21045	10	Og. Citizen of What Country? U.S.A.
	ath w	Funeral	11. Marital Status 12. Was Decedent Eve	rin II S 13. V		Specify Yes or No-	14. Race - American Indian,
ယ္	or ite	by F	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🛣 No		Vas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc.
03	rsaft ural", Exal	ed	3 ☐ Widowed 4 ☐ Divorced	1	x Yes 2 □ No Specify: C	uban	Specify: White
21215-0036	72 hours after death with the Maryland n"natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation aind of work done during most of wo	orkina 1	6b. Kind of Business/Industry
121	within 7. giene. er than t, the Me	mo.	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO	O NOT use retired)		Education
5	is filed within 72 hours after death with the Manyland tal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)	Etelen	tary School Teacher	ame (First, Middle, Ma	
an	d Mental I	인	Emeterio Castillo			ro Betancour	•
Maryland	1 and 2 should be if Health and Meni item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or R		
	and 2 st Health a tem 27 is		Cathy Castillo (Wife)	4.0	·		ryland 21045
ore	of Heal		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State	20b. Place of Dispos	sition (Name of natory or other place)	Date 2	20c. Location - City or Town, State
<u>H</u>	Page ment o tant: If ury or		4 Donation 5 Other (Specify)			5-2012 C	larksville, Maryland
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot once.		21. Signature / Furley   Service Lineace	22	Name and Address of Facility W	itzke Funera	1 Homes, Inc.
	<u> </u>	H	GUTTA		555 Twin Knolls Road		Maryland 21045
п			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	a death. Do not ente	r the mode of dying, such as cardia	c or respiratory arrest	t, Approximate Interval Between Onset and Death
die	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		e to thrive		Onset and Death
-	Examiner		Due to (or as a co	insequence of):			
		ner		insac uantos off			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c				11
	executed ian and urial-transi	ũ	resulting in death) Last Due to (or as a co	onsequence of):			
09	death certificate be executed re attending physician and ed for use as the burial-transit	dical	d				
387	irtifica ling p		IF FEMALE:				
Box 687	eath certifica attending p for use as	cian	in the past 12 months?	Fetal death 3 🗆	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
		Physician/M	1 Yes 2 No 4 Pregnant at tir 9 Unknown 9 Unknown	le oi dealii 5 🖵	Other (specify)		
P.O.	that the		Part II. Other significant conditions contributing to death but r	not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
S,	requires that been signed k should be det	Completed by		_		1 ☐ Yes	2 No 3 Probably 4 Unknown
Ö	w req s bee 2 sho	plet				24a. Was an	24b. Were autopsy findings available
3ec	sician: The law r s certificate has t director, page 2 s	mo;			1777	autopsy perform 1 \(\superset\) Yes 2	prior to completion of cause of death?
B	ian: 1 ertifica etor, 1	Be C	25. Was case referred to medical examiner?		26. Place of Death (Che		2 10 12 10 22 10
5	Physic this ce ral dire	ဂ္	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatient	Other: 4 Nursing I	Home 5 Residen	ce 6 Other (Specify)
0	ling P	ate:	27. Manner of Death  1 ☒ Natural  5 ☐ Pending  28a. Date of injury (Month, Day, Ye	28b. Time of injury	28c. Injury at work?	28d. Describe how	injury occurred
Sior	death death stor: / y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	At home form stre	M 1 Yes 2 No	006   000	2 12 1
Division of Vital Records,	lor A after Direct	Cer	4 Homicide determined building, etc. (S	- At home, farm, stre specify)	et, factory, office	City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	ical	29a. Certifier 1 Eertifying Physician: To the best of my				
	he Hk in 24 in Fu pletel	Medical	(Check 2 Medical Examiner; On the basis of examonly one) 3 Certifying Nurse Practitioner: To the basis				place, and due to the cause(s) and manner stated. cause(s) and manner as stated.
	<b>To the</b> within 2 <b>To th</b> е сотре		29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month, Day, Year)
	200		· KCI-UOL		D+3821		8/14/12
	2/11		30. Name and address of person who completed cause of death	0	rint)	A (18)	Mills, mo 21117
	Stat		31. Date filed (Month, Day, Year) 32. Registrar		30x 1525	nonver	171113 1711 11114
	Stat Registra		AUG 1 5 2012 General B.	gake		-	

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